

**FULL BOARD MEETING**  
**Friday, August 19, 2016**



**Hilton Sacramento Arden West**  
**2200 Harvard Street**  
**Sacramento, CA 95815**



## **BOARD MEETING AGENDA**

**August 19, 2016**

Hilton Sacramento Arden West  
2200 Harvard Street, Sacramento, CA 95815  
916-604-3993 (Hotel) or 916-263-2300 (Board Office)

### **Members of the Board**

Steven Morrow, DDS, MS, President  
Judith Forsythe, RDA, Vice President  
Steven Afriat, Public Member, Secretary

Fran Burton, MSW, Public Member  
Yvette Chappell-Ingram, Public Member  
Katie Dawson, RDH  
Kathleen King, Public Member  
Ross Lai, DDS

Huong Le, DDS, MA  
Meredith McKenzie, Public Member  
Thomas Stewart, DDS  
Bruce Whitcher, DDS  
Debra Woo, DDS

During this two-day meeting, the Dental Board of California will consider and may take action on any of the agenda items, unless listed as informational only. It is anticipated that the items of business before the Board on the first day of this meeting will be fully completed on that date. However, should an item not be completed, it may be carried over and heard beginning at 9:00 a.m. on the following day. Anyone wishing to be present when the Board takes action on any item on this agenda must be prepared to attend the two-day meeting in its entirety.

Public comments will be taken on agenda items at the time the specific item is raised. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. Time limitations for discussion and comment will be determined by the President. For verification of the meeting, call (916) 263-2300 or access the Board's website at [www.dbc.ca.gov](http://www.dbc.ca.gov). This Board meeting is open to the public and is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Karen M. Fischer, MPA, Executive Officer, at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, or by phone at (916) 263-2300. Providing your request at least five business days before the meeting will help to ensure availability of the requested accommodation.

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources or technical difficulties that may arise.

# Friday August 19, 2016

## 9:00 A.M. OPEN SESSION – FULL BOARD

15. Call to Order/Roll Call/Establishment of Quorum.
16. Executive Officer's Report.
  - Staffing Update – Vacancies and New Hires
  - Update on the Republic of Moldova Dental School Application
  - Update on Controlled Substance Utilization Review and Evaluation System (CURES) Registration
  - Follow-up on Ethnicity Statistics for California Dental School Students
  - Update on the California Society of Periodontists Request for the Dental Board of California's Endorsement of their Efforts in the Creation of a Periodontal Disease Awareness Month
  - Collection of Email Addresses/Answering Phones and Callbacks
  - Update on Registered Dental Assistant Candidate Guide
  - Update on Section 1115 Medicaid Waiver
17. Report of Dental Hygiene Committee of California (DHCC) Activities
18. Subcommittee Report Regarding the Progress of the Pediatric Anesthesia Study Requested by Senator Jerry Hill; Review and Discussion of "Working Document".
19. Legislation:
  - A. 2016 Tentative Legislative Calendar
  - B. Discussion and Possible Action on the Following Legislation
    - ❖ AB 2235 (Thurmond) Board of Dentistry: Pediatric Anesthesia: Committee
    - ❖ AB 2331 (Dababneh) Dentistry: Applicants to Practice
    - ❖ AB 2485 (Santiago) Dental Corps Loan Repayment Program
    - ❖ AB 2859 (Low) Professions and vocations: retired category: licenses
    - ❖ SB 482 (Lara) Controlled Substances: CURES database
    - ❖ SB 1155 (Morrell) Professions and Vocations: Licenses: Military Service
    - ❖ SB 1348 (Cannella) Licensure Applications: Military Experience
    - ❖ SB 1444 (Hertzberg) State Government: Computerized Personal Information Security Plans
    - ❖ SB 1478 (Senate Committee Business Professions and Economic Development) Healing Arts
  - C. Update on Pending Regulatory Packages
    - Abandonment of Applications (Cal. Code of Regs., Title 16, Section 1004)
    - Dental Assisting Comprehensive Regulatory Proposal; (Cal. Code of Regs., Title 16, Division 10, Chapter 3)

- Elective Facial Cosmetic Surgery Permit Application and Renewal Requirements (New Regulation)
- Licensure By Credential Application Requirements (New Regulation)
- Continuing Education Requirements and Basic Life Support Equivalency Standards (Cal. Code of Regs., Title 16, Sections 1016 and 1017)
- Mobile Dental Clinic and Portable Dental Unit Registration Requirements (Cal. Code of Regs., Title 16, Section 1049)
- Dental and Dental Assistant Fee Increase (Cal. Code Regs., Title 16, Sections 1021 and 1022)
- Definitions for Filing and Discovery (New Regulation)

D. Discussion and Possible Action Regarding Fiscal Year 2016/17 Regulatory Priorities

E. Discussion of Prospective Legislative Proposals.

Stakeholders Are Encouraged to Submit Proposals in Writing to the Board Before or During the Meeting for Possible Consideration by the Board at a Future Meeting

20. Fee Increase:

A. Discussion and Possible Action Regarding Comments Received During the 45-Day Public Comment Period and During the Regulatory Hearing for the Board's Proposed Rulemaking to Amend California Code of Regulations, Title 16, Sections 1021 and 1022 Relevant to a Fee Increase.

B. Discussion and Possible Action Regarding Adoption of Proposed Amendments to California Code of Regulations, Title 16, Sections 1021 and 1022 Relevant to a Fee Increase.

21. Public Comment on Items Not on the Agenda.

The Board may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

22. Board Member Comments on Items Not on the Agenda.

The Board may not discuss or take action on any matter raised during the Board Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

23. Adjournment.

**Call to Order**

**Roll Call**

**Establishment of  
Quorum**



## MEMORANDUM

<b>DATE</b>	August 1, 2016
<b>TO</b>	Members, Dental Board of California
<b>FROM</b>	Karen Fischer, Executive Officer
<b>SUBJECT</b>	<b>Agenda Item 16:</b> Executive Officer Report

### **Staffing Update – Vacancies and New Hires as of August 1, 2016**

#### **Administration Unit ~ 1 vacancy**

Associate Governmental Program Analyst (AGPA) – Perm/FT; current incumbent separated as of 05/13/16 and recruitment is in process.

#### **Licensing & Examination Unit ~ 2 vacancies**

Staff Services Analyst – Perm/FT; to be filled with a Limited Term/FT incumbent (date to be determined).

Staff Services Analyst – Perm/PT; previous incumbent accepted a promotion within the Board with a separation date of 07/24/16 and recruitment will be initiated to fill behind.

#### **Dental Assisting Program ~ 2 vacancies**

Management Services Technician (MST) – Perm/FT; current incumbent separated as of 07/14/16 and recruitment is in process.

Office Assistant (General) (OT G) – Limited Term/FT; current incumbent accepted a promotion within the Board at Limited Term/FT with a separation date to be determined. Additionally, there is 1 employee out on an extended leave of absence and recruitment to fill behind at Limited Term/FT is in process.

### **Enforcement Division**

#### **Complaint & Compliance Unit ~ currently fully staffed**

Recently hired:

Staff Services Manager I (SSM I) – Perm/FT effective 06/06/16

Office Technician (Typing) (OT T) – Perm/FT effective 07/01/16

Associate Governmental Program Analyst (AGPA) – Perm/FT effective 08/03/16

#### **Discipline Coordination Unit ~ currently fully staffed**

Recently hired:

Associate Governmental Program Analyst (AGPA) – Perm/PT effective 07/25/16

**Investigative Analysis Unit ~ 1 upcoming vacancy**

Associate Governmental Program Analyst (AGPA) – Perm/FT; current incumbent gave notice to separate as of 08/31/16 and recruitment will be initiated to fill behind.

Recently hired:

Special Investigator (Sp Inv) – Perm/FT effective 08/02/16

Staff Services Manager I (SSM I) – Perm/FT effective 08/15/16

**Sacramento Field Office ~ 1 vacancy**

Investigator (INV) – Perm/FT; candidate currently in the final hiring phase with effective date to be negotiated within a week.

**Orange Field Office ~ 3 vacancies and 1 upcoming vacancy**

3 Investigators (INV) – Perm/FT; currently there are 3 potential candidates nearing the first phase of background for these vacancies.

Investigator (INV) – Perm/FT; current incumbent gave notice to separate as of 08/07/16 and recruitment will be initiated to fill behind.

**Total number of hires/separations since May 1, 2016:**

Hires – 6

Separations – 3

**Update on the Republic of Moldova Dental School Application**

The Site Visit of the Moldova Dental School is scheduled for October 1-8, 2016. Travel arrangements are being made for the four members of the Site Evaluation Team. Members include Dr. Steven Morrow, Dr. Timothy Martinez, and Dr. Octavia Plesh. Zachary Raske is the staff member who will be accompanying the team. Prior to the site visit, the Team will meet twice, August 23 and September 20, to review the application and prepare for the site visit.

**Update on Controlled Substance Utilization Review and Evaluation System (CURES) Registration**

A verbal report will be given at the meeting.

**Follow-up on Ethnicity Statistics for California Dental School Students**

At the May meeting, following the President's report regarding a snapshot of dental education nationally in 2015-2016, a member asked for additional statistics relating specifically to ethnicity in California dental schools. An attachment containing this information is included following this memo.

**Update on the California Society of Periodontists Request for the Dental Board of California's Endorsement of their Efforts in the Creation of a Periodontal Disease Awareness Month**

In February 2016, the Dental Board received a letter from Mark Fagan, DDS, MS, and President of the California Society of Periodontists (CSP) requesting the Board's endorsement of CSP's efforts to create a periodontal disease awareness month. The goal is to raise awareness of the prevalence and significance of periodontal disease and to provide education on how best to prevent, recognize, and appropriately treat this disease that affects the majority of the adult population. Dr. Nicolas Kaplanis, President Elect of

CSP attended the May board meeting to present the request. There was discussion by board members and in the end, Dr. Morrow asked that staff research options and bring a recommendation back to the August meeting.

Laura Purcell, Executive Director of CSP notified me that her organization is working with other associations to gather support. Additional information will be available for discussion at a future meeting.

#### **Collection of Email Addresses/Answering Phones and Callbacks**

The statutory deadline for licensees (dentists, registered dental assistants (RDAs), and registered dental assistants in extended functions (RDAEFs) to register an email address with the Board was July 1<sup>st</sup>; and the Board has collected over 30,000 email addresses. We will be sending out an insert in the license/permit renewals – reminding licensees of this requirement. Staff is collecting email addresses at every opportunity including at a booth at the upcoming CDA Presents in San Francisco, when speaking with callers about other issues, and when walk-ins come to the office to conduct business.

Regarding phone calls and callbacks – staff has been checking the voicemail buckets hourly. The expectation is that staff returns calls within 1-2 business days. Messages are being tracked and reviewed by the management team.

#### **Update on Registered Dental Assistant Candidate Guide**

Board staff worked with the Office of Professional Examination Services (OPES) to develop a Registered Dental Assistant Candidate Guide which will be released August 15<sup>th</sup>; and will be available on the Board's website. The Guide will be distributed to candidates when scheduling letters are mailed. Program Directors will also receive a copy of the Guide.

#### **Update on Section 1115 Medicaid Waiver**

The California State Dental Director has been asked to provide an update on this issue.



### Ethnicity by School 2011-2016

UOP	WHITE	BLACK	HISPANIC	AMERICAN INDIAN OR ALASKAN NATIVE	ASIAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	TWO OR MORE RACES	NON-RESIDENT ALIEN	NOT SPECIFIED	TOTAL
	2011/12	188	6	28	0	220	0	11	0	19
2012/13	195	0	20	0	228	0	19	0	1	463
2013/14	180	0	28	2	235	1	20	0	3	469
2014/15	60	0	8	0	65	1	6	0	3	143
2015/16	171	3	3	2	239	0	27	0	13	458

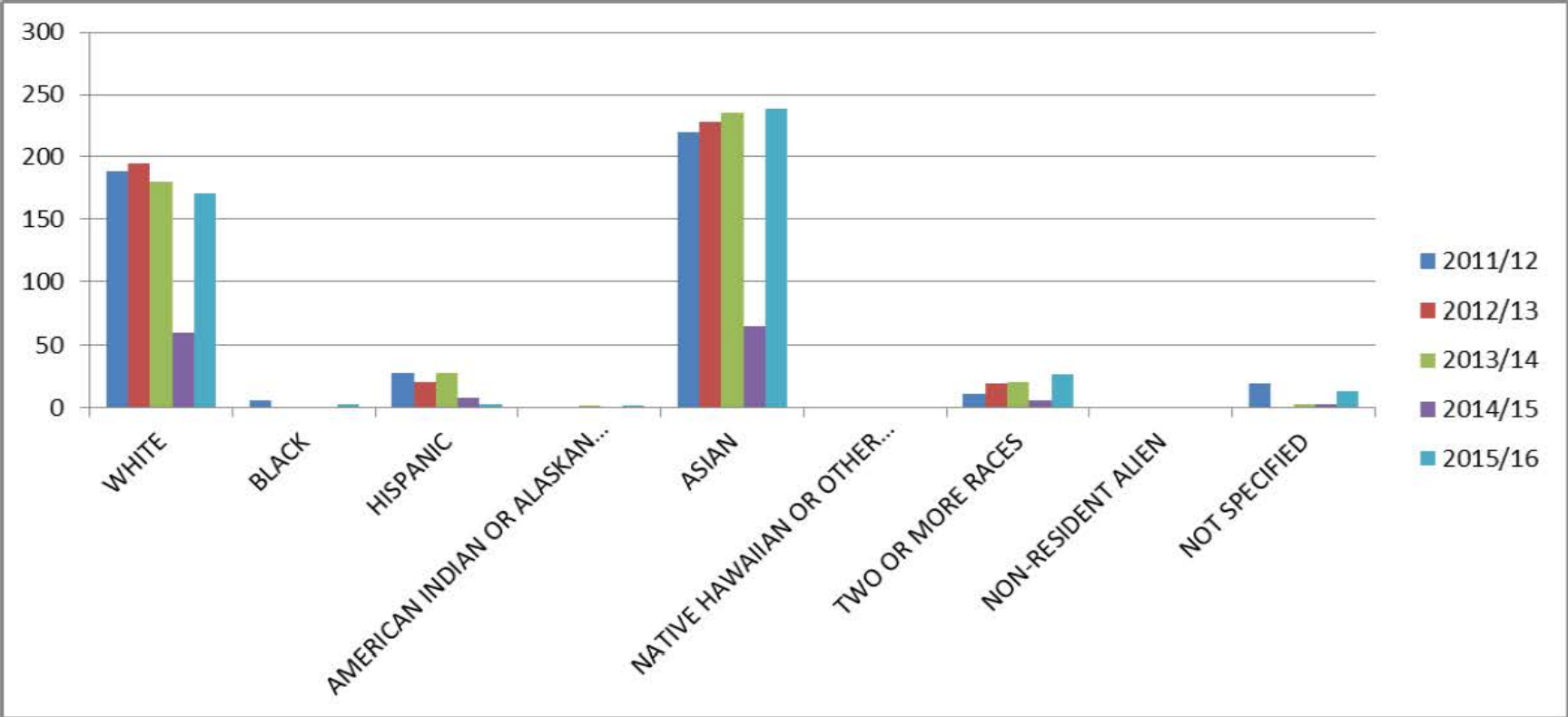
UCSF	WHITE	BLACK	HISPANIC	AMERICAN INDIAN OR ALASKAN NATIVE	ASIAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	TWO OR MORE RACES	NON-RESIDENT ALIEN	NOT SPECIFIED	TOTAL
	2011/12	128	4	36	3	178	0	2	3	35
2012/13	112	7	44	3	160	0	2	33	31	392
2013/14	90	7	52	2	161	1	9	35	36	393
2014/15	30	5	8	0	43	1	3	0	1	90
2015/16	88	12	41	0	168	1	23	0	14	275

UCLA	WHITE	BLACK	HISPANIC	AMERICAN INDIAN OR ALASKAN NATIVE	ASIAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	TWO OR MORE RACES	NON-RESIDENT ALIEN	NOT SPECIFIED	TOTAL
	2011/12	136	9	25	2	164	8	5	13	20
2012/13	123	8	21	2	197	8	7	14	11	391
2013/14	109	7	28	2	187	10	17	33	5	398
2014/15	26	2	4	0	49	1	3	2	2	89
2015/16	89	7	25	1	213	12	4	31	6	388

USC	WHITE	BLACK	HISPANIC	AMERICAN INDIAN OR ALASKAN NATIVE	ASIAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	TWO OR MORE RACES	NON-RESIDENT ALIEN	NOT SPECIFIED	TOTAL
	2011/12	268	21	35	2	221	2	4	71	15
2012/13	156	22	36	1	231	5	8	62	18	639
2013/14	260	21	39	1	217	7	12	64	16	637
2014/15	44	8	13	0	42	0	3	0	0	101
2015/16	217	21	48	1	220	10	16	80	39	653

LOMA LINDA	WHITE	BLACK	HISPANIC	AMERICAN INDIAN OR ALASKAN NATIVE	ASIAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	TWO OR MORE RACES	NON-RESIDENT ALIEN	NOT SPECIFIED	TOTAL
	2011/12	171	21	36	0	186	0	35	0	1
2012/13	174	18	37	0	198	0	21	1	1	450
2013/14	149	20	44	0	180	0	17	38	1	449
2014/15	35	8	13	0	42	0	3	0	0	101
2015/16	167	21	47	1	173	0	18	0	0	427

WESTERN	WHITE	BLACK	HISPANIC	AMERICAN INDIAN OR ALASKAN NATIVE	ASIAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	TWO OR MORE RACES	NON-RESIDENT ALIEN	NOT SPECIFIED	TOTAL
	2011/12	82	6	10	4	97	0	4	0	15
2012/13	0	0	0	0	0	0	0	0	0	0
2013/14	103	6	17	2	120	0	16	3	15	282
2014/15	25	0	11	0	23	0	5	0	3	67
2015/16	92	3	34	3	106	0	23	0	14	275





## MEMORANDUM

<b>DATE</b>	June 21, 2016
<b>TO</b>	Dental Board of California
<b>FROM</b>	Linda Byers, Executive Assistant
<b>SUBJECT</b>	<b>Agenda Item 17:</b> Update from the Dental Hygiene Committee of California (DHCC)

A representative from the Dental Hygiene Committee of California will provide a verbal report.



## MEMORANDUM

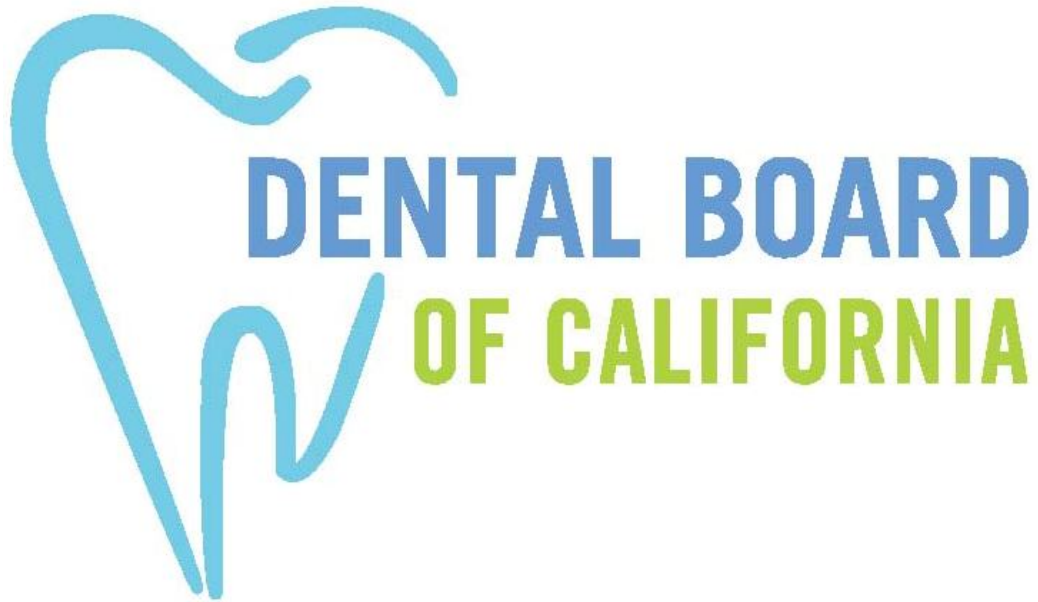
<b>DATE</b>	August 1, 2016
<b>TO</b>	Members, Dental Board of California
<b>FROM</b>	Karen Fischer, Executive Officer
<b>SUBJECT</b>	<b>Agenda Item 18:</b> Subcommittee Report Regarding the Progress of the Pediatric Anesthesia Study Requested by Senator Jerry Hill; Review and Discussion of "Working Document".

The Subcommittee completed its first draft of the Pediatric Anesthesia Report; and mailed the "working document" to interested parties on July 18, 2016. Included with the document was an invitation to attend a workshop in Sacramento on July 28<sup>th</sup> to discuss the draft. The workshop was webcast and has been archived for future viewing. Those in attendance included legislative consultants from Senator Hill's office and Assembly member Thurmond's office, the public, the Media (NBC and ABC), and representatives from the following organizations:

- American Academy of Pediatrics
- California Association of Nurse Anesthetists
- California Dental Association
- California Society of Anesthesiologists
- California Society of Dental Anesthesiologists
- Oral and Facial Surgeons on California

Many participants acknowledged the Board for the work put into the working document so far. There are no recommendations for statutory and/or regulatory changes from the Subcommittee at this time. The Subcommittee anticipates that consensus recommendations will be developed through additional meetings with stakeholders and interested parties before bringing any recommendations before the full board for consideration.

The Subcommittee will lead the discussion of the working document.



# **PEDIATRIC ANESTHESIA STUDY**



# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

## Draft Subcommittee Report

### Dental Board of California

#### Safety of deep sedation and general anesthesia for pediatric dental treatment

#### Introduction

In February 2016 The Dental Board received a request from Senator Jerry Hill to form a subcommittee to investigate whether California's present laws, regulations and policies are sufficient to guard against unnecessary use of general anesthesia in the treatment of pediatric patients, and whether these laws assure patient safety.

In addition the letter requested that the subcommittee review all incident reports related to pediatric anesthesia for the past 5 years, and to review other states' and dental associations policies.

The subcommittee has reviewed and is reporting on the following:

1. The present laws, regulations, and policies in California; and a comparison of these laws, regulations and policies to those of other states and dental associations .
2. All incident reports related to pediatric sedation, including conscious sedation, oral conscious sedation, and general anesthesia as well as administration of local anesthetic in California for the past six years (2010-2015).
3. Review of relevant dental and medical literature

#### Background

##### History of Anesthesia and the Scope of Practice of Dentistry

Although both dentists and physicians contributed to early developments in the field of anesthesiology, each profession evolved differently. Advances in medical anesthesiology evolved slowly until 1923 when a few physicians had the novel idea of creating a separate department of anesthesia in medical schools. This advance allowed all teaching, training, and research endeavors to be organized and supervised by one department head. This marked the beginning of medical anesthesiology as a scientific discipline.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

The practice of anesthesiology in dentistry took a different path, with dentists practicing various forms of anesthesia as a technique taught by practitioners to one another. This approach did not initially provide an environment for formal research. Anesthesia techniques developed specifically for dentistry became more widely accepted by the profession in the middle of the 20th century. Drs. Morgan Allison, Adrian Hubbell, Leonard Monheim and others first utilized new techniques and new anesthetics that became available at the time. Other dentists developed what was then a new technique, termed “conscious sedation” which utilized sub anesthetic doses of general anesthetic drugs along with local anesthesia. These new anesthesia concepts and ideas led to the establishment of the American Dental Society of Anesthesiology (ADSA) in 1953. Among the chief goals of these pioneer dentists was to provide education in advanced pain and anxiety control for all dentists.

Case law has clarified the place of anesthesia within the scope of dental practice. The courts that have reviewed anesthesia scope of practice cases have consistently viewed anesthesiology as being within the scope of practice of dentistry as well as other health care disciplines. However the courts have ruled that individual providers are limited to their scope of practice as defined by state law. Anesthesia should therefore be administered according to the statutes and regulations that each state uses to govern an individual’s core license to practice.<sup>1</sup>

## **History and Function of the Dental Board of California Board**

The California legislature created the Dental Board of California (DBC or Board) in 1885 to regulate the practice of dentistry. Today, the Board regulates the approximately 86,000 licensed dental healthcare professionals in California, including approximately 40,000 dentists, 44,000 registered dental assistants (RDAs) and 1,500 registered dental assistants in extended functions (RDAEFs). In addition, the Board is responsible for setting the duties and functions of approximately 50,000 unlicensed dental assistants. The Board's last sunset review was in 2014.

The practice of dentistry is defined in Business and Professions Code section 1625 as:

*“the diagnosis or treatment, by surgery or other method, of diseases and lesions and the correction of malpositions of the human teeth, alveolar process, gums, jaws, or associated structures; and such diagnosis or treatment may include all necessary related procedures as well as the use of drugs, anesthetic agents, and physical evaluation.”*

---

<sup>1</sup> Boynes, S.G., A Guide to Dental Anesthesiology Rules and Regulations, 5<sup>th</sup> ed., Chicago, No-No Orchard Publishing, 2013. P33.

[http://www.mediafire.com/download/b0p8rhh9imk4939/Fifth\\_Edition\\_Dental\\_Anesthesiology\\_Guide\\_to\\_the\\_Rules\\_and\\_Regulations.pdf](http://www.mediafire.com/download/b0p8rhh9imk4939/Fifth_Edition_Dental_Anesthesiology_Guide_to_the_Rules_and_Regulations.pdf)



# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

The Board meets at least four times throughout the year to address work completed by the various committees, and as noticed on the agenda, may meet in closed session as authorized by Government Code Section 11126 et. seq.

The mission of the Dental Board is defined in Business and Professions Code section 1601.2, which states:

*“Protection of the public shall be the highest priority for the Dental Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.”*

To meet its obligations, the Board implements regulatory programs and performs a variety of functions. These programs and activities include setting licensure requirements for dentists and dental assistants, including examination requirements, and issuing and renewing licenses, including a variety of permits and certifications. The Board also has its own enforcement division, with sworn and non-sworn staff, which is tasked with investigating both criminal and administrative violations of the Dental Practice Act (Act) and other laws. As part of the disciplinary function of the Board, it also monitors dentists and RDAs who may be on probation, and manages a Diversion Program for licensees whose practice may be impaired due to abuse of dangerous drugs or alcohol.

## **Board Membership and Committees**

The Board is composed of 15 members: eight practicing dentists, one registered dental hygienist (RDH), one RDA, and five public members, which account for one-third of the membership. The Governor appoints the dentists, the RDH, the RDA, and three public members. The Speaker of the Assembly and the Senate Rules Committee each appoint one public member. Of the eight practicing dentists, one must be a member of the faculty of any California dental school, and one is required to be a dentist practicing in a nonprofit community clinic. Members of the Board are appointed for a term of four years, and each member may serve no more than two full terms.

## **Purpose of State Laws**

State laws and regulations are general rules governing people's rights or conduct. Laws and regulations do not contain recommendations, model procedures, lists of resources, or information about practice or procedures, otherwise known as guidance documents.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Laws are developed following a legislative plan that includes an analysis of the existing law, an analysis of the necessity of legislation, a statement that no other regulatory choice would be effective; analysis of potential danger areas (constitutional, legal, practical); and an analysis of the practical implications of the legislative proposal. Regulations are developed to implement, interpret, and make specific the law. Statutes and regulations are of necessity concise and in the case of dental laws, establish the minimum standards for the safe practice of dentistry. Laws and regulations are usually applied literally and can limit the ability of the licensee to exercise discretion.

## **Dental Board Enforcement Unit**

The Dental Board utilizes its disciplinary process to enforce the Dental Practice Act. The board has broad authority over its licensees and may issue administrative citations, impose fines, and reprimand, revoke, suspend, or place conditions upon a dental license. All complaints against a licensee are reviewed and if there is sufficient evidence of professional misconduct an accusation is filed.

Accusations may be based on specific acts or omissions of those duties described in the Practice Act, or as established by expert testimony of gross negligence or incompetence sufficient to require discipline. This provision makes it unnecessary to state every conceivable practice standard, as to do so would clearly be impractical.

## **Definitions Used in Dental Sedation and Anesthesia**

The American Society of Anesthesiology developed new definitions of levels of sedation in 1999. These definitions were subsequently adopted by most other organizations involved in the provision of sedation and anesthesia care. The Dental Board first suggested adoption of these definitions into its laws in 2005 and again in 2010.

Appendix 1 Table 1 includes a side by side comparison of California's current definitions of oral conscious sedation, parenteral conscious sedation, and general anesthesia with contemporary definitions.

- **analgesia** – the diminution or elimination of pain.
- **anxiolysis** – the diminution or elimination of anxiety.
- **conscious sedation** – a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

- **deep sedation** – an induced state of depressed consciousness accompanied by partial or complete loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to physical stimulation or verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.
- **enteral** – any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa.
- **general anesthesia** – an induced state of unconsciousness accompanied by partial or complete loss of protective reflexes, including the inability to continually maintain an airway independently and respond purposefully to physical stimulation or verbal command, and is produced by a pharmacological or non-pharmacological method or combination thereof.
- **incremental dosing** – administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).
- **inhalation** – a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.
- **local anesthesia** – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.
- **maximum recommended dose (MRD)** – maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.
- **minimal sedation** - a minimally depressed level of consciousness produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected. In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.
- **moderate sedation** – a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- **parenteral** – a technique of administration in which the drug bypasses the gastrointestinal tract.
- **recovery** – the ability to regain full health, or a return to baseline status.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

- **supplemental dosing** - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures.
- **titration** – the administration of small incremental doses of a drug until a desired clinical effect is observed.
- **transdermal** – a technique of administration in which the drug is administered by patch or iontophoresis through skin.
- **transmucosal** – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

## **Dental Board General Anesthesia, Conscious Sedation and Oral Conscious Sedation Permit Program**

### **Legislative history**

The California Dental Practice Act regulates the use of sedation and general anesthesia by California dentists. These laws and regulations may be accessed through the Dental Board of California's website. There is an annual publication of the California Dental Practice Act that is available from the legal and professional document publisher Lexis Nexis.

The Dental Board of California has long sought to improve the safety of sedation and anesthesia in California. The Board, working with the California Dental Association, co sponsored SB 386 (Keene, 1979), the first legislation to regulate the use of general anesthesia by dentists in California. This bill included a requirement for mandatory office inspections that were based on a voluntary program originally developed by Southern California oral surgeons. Conscious sedation laws, AB 1276 (Tucker, 1986) also sponsored by the Board and CDA, followed as did AB 2006 (Keeley, 1998) and AB 1386 (Laird, 2005), the most recent update of sedation laws. None of this legislation was prompted by a crisis related to the administration of sedation or anesthesia. These laws were sponsored as proactive measures to improve patient safety. An exception was AB 564 (Keene, 2001), a bill that established reporting requirements for patient deaths, that was introduced at the request of a mother whose son suffered brain damage after he was given chloral hydrate, an oral sedative, by his dentist.

In 2002 the Board called for a review of anesthesia laws and patient outcomes to see if any improvements could be made to the existing regulatory program. To accomplish this goal the Board appointed the Blue Ribbon Panel on Anesthesia, an ad hoc committee composed of general dentists and dental specialists who were recognized experts in the field. The Blue

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Ribbon Panel reviewed laws in other states, dental association guidelines, death statistics provided by the Dental Board, closed claims from an insurance carrier, as well as current laws.

The Blue Ribbon Panel's recommendations were approved by the Board and ultimately enacted through statute and regulation beginning in 2006.<sup>2</sup> There is no record of any significant opposition to the recommended changes which included the addition of an adult oral conscious sedation permit, new requirements for pre anesthetic physical evaluation of patients, and improvements to the office inspection program. The Panel did not recommend that a specific number of personnel be present, nor was there any recommendation for staff training other than Basic CPR. There was no recommendation for pre operative dietary instructions due to controversy about appropriate requirements. At the time the board was aware of the need to update anesthesia terminology to achieve consistency with new definitions adopted by the American Dental Association, but chose to defer this until a later date, and recommended that these changes be made during sunset review.

In 2010 the Board president appointed a subcommittee to study the definitions, to make recommendations for their adoption and to review the relevant statutes and regulation for currency. The 2010 subcommittee recommended that the anesthesia and sedation laws be should reviewed and updated every 5 years and suggested strategies for accomplishing this task. Once statutes were amended other changes could be implemented by regulation. A series of informal stakeholder meetings followed and the subcommittee submitted a legislative proposal to the board in November 2013. This item was noticed for discussion and possible action at the November 22, 2013 meeting. The California Society of Pediatric Dentists stated support but provided no specific comments. No action was taken due to other pressing business and the proposal was identified as a future board priority.

## **Current California Sedation and Anesthesia Laws**

A summary of California's current dental sedation and anesthesia laws is provided in the attached Appendix 2, Tables 2-8. California Business and Professions Code sections 1646.2, 1646.4, 1646.9, 1647.3, 1647.5, 1647.7 describe educational qualifications and other requirements necessary for a dentist to become eligible for a permit to administer general anesthesia or sedation and to renew such permit. These laws include a requirement for general anesthesia and conscious sedation permit holders to undergo an office inspection every 5 -6 years; completion of continuing education every 2 years; a list of violations that are considered unprofessional conduct; and requirements for a physician and surgeon to obtain a permit to administer general anesthesia in a dental office. Business and Professions Code sections 1680

---

<sup>2</sup> Dental Board of California: Recommendations of the Blue Ribbon Panel, November 7, 2003.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

and 1682 describe acts that constitute unprofessional conduct specifically related to sedation and anesthesia.

Business and Profession Code 1647 addresses conscious sedation and includes the statement that “the drugs and techniques used shall have a margin of safety wide enough to render unintended loss of consciousness unlikely”. This broad approach to limiting the use of potent sedatives recognizes that almost any drug or combination of drugs, when used in sufficient quantity, can produce loss of consciousness, particularly in the very young, very old and medically compromised patients.

The duties of dental assistants are described in Business and Professions Code section 1750.1. This section includes patient monitoring and other sedation related duties they may perform. California Code of Regulations Section 1070 and 1070.2 specify the educational course and program requirements and approval process for dental assistants, including the Dental Sedation Assistant.

California Code of Regulations sections 1043 and 1044 provide requirements for supervision of sedated patients, definitions of levels of sedation, and additional details of permit requirements. The California Code of Regulations section 1043.3 and 1043.4 provide the details of the office inspection program including composition of the inspection team; office facility requirements; equipment requirements, including patient monitors; preoperative evaluation; records; emergency drugs; conduct of the evaluation including a demonstration of general anesthesia and performance of the 13 simulated emergencies; and administrative procedures for the office evaluation process. The Dental Board of California presently issues the following permits:

1. Pediatric oral conscious sedation
2. Adult oral conscious sedation
3. Parenteral conscious sedation
4. General anesthesia
5. Physician anesthesiologist dental anesthesia

<b>Permit type</b>	<b>Current Active</b>	<b>Delinquent</b>	<b>Total canceled</b>
General Anesthesia	837	37	846
Conscious Sedation	514	32	393
Adult Oral Cons. Sed.	1418	564 ( adult+peds)	458 (adult + peds)
Pediatric Oral CS	1523		
Medical GA	87	27	155

Permit totals as of March 2016

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

## Dental Sedation and Anesthesia Laws in Other States

Compilations of dental sedation and anesthesia laws for all 50 states are available from the American Dental Association<sup>3 4</sup>, the American Dental Society of Anesthesia<sup>5</sup> and the American Association of Oral and Maxillofacial Surgeons<sup>6</sup> These publications provide summaries of all laws and regulations relevant to general anesthesia and deep sedation as well as moderate and minimal sedation in all 50 states. We obtained additional information related to minimal and moderate enteral sedation laws from DOCS Education ( Dental Organization for Conscious Sedation).<sup>7</sup> The Canadian provinces have adopted the American model for dental sedation and anesthesia and utilize a similar regulatory framework. The subcommittee did not review provincial laws for this report.

Laws in California and most other states reference guidelines published by the American Dental Association<sup>8 9</sup> and the educational standards of the Commission on Dental Accreditation of the American Dental Association<sup>10</sup>, and frequently incorporate some but not all of the recommendations included in these guidance documents.

---

<sup>3</sup>American Dental Association, “Statutory Requirements for General Anesthesia and Deep Sedation Permits”, 2009. [http://www.ada.org/en/~media/ADA/Advocacy/Files/anesthesia\\_general\\_permit](http://www.ada.org/en/~media/ADA/Advocacy/Files/anesthesia_general_permit)

<sup>4</sup> American Dental Association, “Statutory Requirements for General Anesthesia and Deep Sedation Permits”, 2009. [http://www.ada.org/en/~media/ADA/Advocacy/Files/anesthesia\\_sedation\\_permit](http://www.ada.org/en/~media/ADA/Advocacy/Files/anesthesia_sedation_permit)

<sup>5</sup>Boynes, S.G., A Guide to Dental Anesthesiology Rules and Regulations, 5<sup>th</sup> ed., Chicago, No-No Orchard Publishing, 2013.

[http://www.mediafire.com/download/b0p8rhh9imk4939/Fifth\\_Edition\\_Dental\\_Anesthesiology\\_Guide\\_to\\_the\\_Rules\\_and\\_Regulations.pdf](http://www.mediafire.com/download/b0p8rhh9imk4939/Fifth_Edition_Dental_Anesthesiology_Guide_to_the_Rules_and_Regulations.pdf)

<sup>6</sup> American Association of Oral and Maxillofacial Surgeons, State Requirements for General Anesthesia Delivery – Summary, Rosemont, IL, updated 4/19/2016.

<sup>7</sup> DOCS Education <http://www.sedationregulations.com/>

<sup>8</sup> American Dental Association. (2012). Guidelines for the Use of Sedation and General Anesthesia by Dentists. In *Society* (Vol. 80, pp. 75–106). <http://doi.org/10.1112/S0024611500012132>  
[http://www.ada.org/en/~media/ADA/Advocacy/Files/anesthesia\\_use\\_guidelines](http://www.ada.org/en/~media/ADA/Advocacy/Files/anesthesia_use_guidelines)

<sup>9</sup> American Dental Association. (2012). Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. In ADA (Ed.), (pp. 1–18). Chicago. Retrieved from: [http://www.ada.org/en/~media/ADA/Member\\_Center/Files/anxiety\\_guidelines](http://www.ada.org/en/~media/ADA/Member_Center/Files/anxiety_guidelines)

<sup>10</sup> Commission on Dental Accreditation: (2012). Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery. Retrieved from <https://www.ada.org/~media/CODA/Files/oms.pdf?la=en>

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

## Comparison of California Laws with Laws in Other States

### Methods

We summarized information from compilations of state laws for this report. Where information was incomplete or missing, we downloaded the practice act for that state from the state board web site and reviewed the relevant sections. If necessary we contacted the individual dental board to obtain additional information. For some states there were questions that required legal interpretation that could not be completely resolved. Texas, South Carolina, and Alaska have rulemaking in progress so we reviewed their existing rules.

Certain state laws and regulations were relatively uniform across all 50 states. We have described these in the narrative. Other state laws were less consistent and we compiled this information into spreadsheets for analysis and presentation in graphical form. Please see Appendix 1 for a graphical summary of state requirements.

The subcommittee made every effort to verify the accuracy of information presented, however due to the variability, complexity, and ever changing nature of state laws and regulations this report may include some inaccuracies. We welcome the opportunity to provide additions or corrections to this information.

The comparison is organized according to the areas outlined below as well as by permit type. We limited the permit types we reviewed to minimal sedation, moderate oral sedation, moderate parenteral sedation, and deep sedation/general anesthesia. Some states issue permits for additional categories.

### Areas of comparison

#### Narrative comparison

- Permitting of practice locations
- Education
- Preoperative evaluation
- Personnel
- Facility
- Monitoring and Equipment
- Records
- Emergency Drugs
- Continuing education
- Pediatric sedation



# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

## Graphical comparison – see Appendix 1

- Office inspection
- Monitoring and equipment
- Personnel
- Pediatric sedation
- Continuing education

## Permit types

- Minimal sedation
- Moderate enteral sedation
- Moderate parenteral sedation
- Deep Sedation/General Anesthesia

## Permitting of practice locations

For the majority of states, including California, the permit to administer sedation or general anesthesia is assigned to the individual dentist and not to a facility. The California Dental Board maintains broad authority over its licensees and may conduct an inspection of any dental facility at its own discretion. Although the majority of states, including California, require a periodic facility inspection, only a single facility utilized by the permit holder is usually inspected. The permit holder is assigned the responsibility for assuring that all facilities where they administer sedation are appropriately equipped and staffed as required by law.

We identified nine (9) states that require of permitting individual practice locations in addition to the dentist. This has the advantage of assuring that facilities are properly equipped but requires a significantly greater number of inspections. In contrast, the Medical Board of California is responsible for the accreditation of all locations where sedation or anesthesia, other than local anesthesia, is administered. Accreditation is done by three different board approved accrediting entities. Practitioners are approved to administer sedation or anesthesia by the individual facility instead of by the regulatory board. For a discussion of the regulatory structure of outpatient facilities in California see the 2015 report from Klutz Consulting.<sup>11</sup>

## Educational requirements

### Minimal Sedation/Anxiolysis training

The American Dental Association defines minimal sedation as “ a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical

---

<sup>11</sup> Outpatient Surgery Services in California: Oversight, transparency and quality. B&R Klutz Consulting, 2015. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20S/PDF%20Sacto07292015OutpatientSurgeryKlutz.pdf>; accessed 6/16/2016.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.”<sup>12</sup>

Minimal Sedation is not defined in the California sedation laws and a permit to administer minimal sedation is not required. According to the ADA educational guidelines training in minimal sedation, including the administration of a mixture of nitrous oxide and oxygen, either alone or in combination with minimal oral sedation, may be taught to the level of basic competency at the predoctoral (dental school) level.<sup>13</sup> Nineteen (19) states require completion of a 16-hour course prior to issuing a minimal sedation permit.

## **Moderate sedation**

Dental practice acts in most states specify that moderate sedation is regulated by route of administration. Sixteen states have recently adopted uniform educational standards for moderate sedation regardless of route of administration.

## **Oral (moderate) conscious sedation certification for adults/minors**

To obtain a California permit for administration of **Oral (moderate) Conscious Sedation Certification for Adults/Minors** the applicant must have completed an approved post doctoral or residency training program that includes sedation training; or, a board approved course that includes 25 hours of instruction including a clinical component utilizing at least one age-appropriate patient; training for either adult patients or minor patients (13 or younger); training requirements reference the ADA and AAP-AAPD definitions of levels of sedation. (See BPC 1647.12; CCR 1044-1044.5.)

## **Moderate parenteral sedation**

In California, to obtain a moderate IV conscious sedation permit, the applicant must complete at least 60 hours of instruction and 20 clinical cases of administration of parenteral (intravenous) conscious sedation for a variety of dental procedures. The course must comply with the requirements of the *Guidelines for Teaching the Comprehensive Control of Anxiety and*

---

<sup>12</sup> [https://www.ada.org/~media/ADA/About%20the%20ADA/Files/anesthesia\\_use\\_guidelines.ashx](https://www.ada.org/~media/ADA/About%20the%20ADA/Files/anesthesia_use_guidelines.ashx)

<sup>13</sup> American Dental Association. (2012). Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. In ADA (Ed.), (pp. 1–18). Chicago. Retrieved from [http://www.ada.org/en/~media/ADA/Member\\_Center/Files/anxiety\\_guidelines](http://www.ada.org/en/~media/ADA/Member_Center/Files/anxiety_guidelines)

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

*Pain in Dentistry* of the American Dental Association as approved by the Board (see BPC 1647.3) The majority of states (37/50) require similar training, also to ADA standards; five states (5) require completion of fewer clinical cases or hours of instruction and four (4) states require more. All states accept proof of completion of a CODA accredited residency program that includes sedation training in lieu of course completion.

California, as well as other states, limit moderate sedation providers to utilizing drugs and techniques that have a margin of safety wide enough to render unintended loss of consciousness unlikely. A few states restrict moderate sedation permit holders from using potent anesthetics such as propofol, methohexital, and ketamine.

## **General anesthesia training**

Educational requirements for a general anesthesia permit issued by the Dental Board of California include either completion of a one year of advanced training in anesthesiology and related academic subjects approved by the Board or equivalent experience as determined by the Board (BPC 1646.2). This requirement is further defined in regulation (see 1043.1) to include either a one year residency in anesthesiology or completion of a Commission on Dental Accreditation (CODA) approved graduate program in oral and maxillofacial surgery.<sup>14</sup> Although this requirement is generally consistent with the laws in the other 49 states there are some variations. For example, some states require completion of either a two year residency in dental anesthesiology or a residency in oral and maxillofacial surgery. Other states require completion of at least 3 years of an oral and maxillofacial residency; others require board certification, but most states (33/50) require completion of an advanced residency education program accredited by the Commission on Dental Accreditation that includes training to competency in general anesthesia. We were unable to identify a state that restricts a general anesthesia permit holder from using any anesthetic agent, including inhalation agents such as Sevoflurane and the intravenous agent propofol.

## **Advanced educational programs that include sedation training**

### **CODA accreditation of advanced educational programs**

Commission on Dental Accreditation (CODA) accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public

---

<sup>14</sup> Commission on Dental Accreditation: (2012). Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery. Retrieved from <https://www.ada.org/~media/CODA/Files/oms.pdf?la=en>

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

recognition for compliance with accepted standards of quality and performance. Accreditation standards are developed in consultation with those affected who represent broad communities of interest. CODA was established in 1975 and is nationally recognized by the United States Department of Education (USDE) as the sole agency to accredit dental and dental-related education programs conducted at the post-secondary level. A comparison table of CODA accreditation standards for advanced residency programs that include training in sedation and general anesthesia is attached, see **“Educational programs that include training in moderate sedation, deep sedation, and general anesthesia”**.

## **American Dental Association (ADA) Educational Guidelines**

The ADA “Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students” are educational guidelines published by the ADA for programs and courses that teach sedation techniques.<sup>15</sup> These Guidelines have been revised periodically but have been relatively consistent for the past 16 years. The Guidelines for teaching moderate sedation are summarized below. The Guidelines do not address training in deep sedation and general anesthesia and defer to the CODA standards for advanced educational programs, stating that these are advanced specialty techniques. The ADA educational guidelines are summarized as follows:

### **Moderate Enteral Sedation**

- a minimum of 24 hours of instruction plus management of at least 10 adult case experiences (at least 3 live patients in groups no larger than 5 with remainder being on mannequins or by virtual reality)
- participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management to prevent office emergencies
- clinical experience is provided in managing healthy adult patients
- course is not designed for the management of children (age 12 and under)
- additional supervised clinical experience is necessary to prepare participants to manage medically compromised adults (ASA PS II-IV) and special needs patients

---

<sup>15</sup> American Dental Association. (2012). Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. In ADA (Ed.), (pp. 1–18). Chicago.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

## **Moderate Parenteral Sedation**

- a minimum of 60 hours of instruction plus management of at least 20 patients by the intravenous route per participant is required to achieve competency in moderate parenteral sedation.
- participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management for prevention of emergencies
- typically clinical experience provided in managing healthy adult patients (not ASA PS II-IV)
- additional supervised clinical experience is necessary to prepare participants to manage children (age 12 and under) and medically compromised adults.

## **Continuing Education Requirements**

Forty seven states, including California, require general anesthesia permit holders to maintain current certification in Advanced Cardiac Life Support (ACLS). The majority of states, other than California, also require moderate sedation permit holders to complete ACLS. Seventeen states require completion of a Pediatric Advanced Cardiac Life Support (PALS) course usually in practices where children are treated. California does not presently require completion of PALS training. Some professional association guidelines, including the AAP-AAPD Guidelines, recommend completion of PALS training.

Twenty nine states (29), including California, require completion of continuing education courses as a condition of renewal of a sedation or anesthesia permit. Most states require continuing education specifically related to sedation or anesthesia. California requires the completion of 25 hours of anesthesia related continuing education every 2 years for a general anesthesia permit, the most of any state, and requires 12 hours per renewal for conscious sedation and 7 hours for oral sedation. California's continuing education requirements therefore exceed those of most other states.

## **Preoperative evaluation**

California law requires a preoperative evaluation for all patients undergoing sedation or anesthesia prior to each administration of sedation or anesthesia. This includes an adequate medical history and a focused physical evaluation recorded and updated as indicated. Records must include but are not limited to the recording of the age, sex, weight, physical status (American Society of Anesthesiologists Classification I-V), medication use, any known or suspected medically compromising conditions, rationale for sedation of the patient, and visual examination of the airway, and for general anesthesia only, auscultation of the heart and

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

lungs as medically required.( CCR 1043.3) All other states reviewed have equivalent or lesser requirements.

## **Personnel**

California law requires patients undergoing sedation or anesthesia to be monitored on a one-on-one ratio until fully recovered. In contrast, thirty three (33) other states require that a prescribed number of staff members be present during administration of sedation or general anesthesia. The American Dental Association Guidelines and AAP-AAPD Guidelines recommend that a minimum of two persons, in addition to the dentist, are present whenever general anesthesia or deep sedation is administered; one person in addition to the dentist should be present for the administration of moderate or minimal sedation.

## **Staff training and qualifications**

Nearly all states (44/50) including California, require dental assistants to maintain current certification in basic cardiac life support, and most require completion of a provider CPR course that includes use of the AED. Although dental assistants may assist with dental treatment, including sedation and anesthesia care under supervision, practice acts in most states prohibit the administration of anesthesia, other than local anesthesia, by dental assistants or dental hygienists.

Twenty nine (29) states require that an individual be designated to monitor patients undergoing sedation or anesthesia , to observe vital signs including pulse, blood pressure, oxygenation, ventilation and circulation. Fourteen states (14) , including California, specify the duties and education for dental assistants participating in sedation and anesthesia care.

California Business and Profession Code sections (BPC 1750.1 (a) (16-18)) and BPC 1750.5 describe the monitoring and assisting duties that a dental assistant may perform under general supervision of a licensed dentist. See Appendix 2, Table 4, *Personnel* .

The supervising dentist is also responsible for ensuring that assistants in his or her employ complete required courses, including California law, infection control, and an approved CPR course.

## **Specialty training for dental assistants**

Since 1967, The California Association of Oral and Facial Surgeons has sponsored a training course for dental assistants. The course consists of 24 hours of didactic education, including 10 hours of lecture, completion of progress exams and 14 hours of home study followed by completion of a written exam. Upon successful course completion the assistant is provided

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

with a certificate of completion. A similar course for assistants is offered by the AAOMS but includes a psychometrically validated exam given at secure testing centers.

Dental assistants may complete a Dental Sedation Assisting Course following one year of employment. (BPC 1750.4, 1750.5). This course must be approved by the Board and requires completion of 40 hours of didactic education, 28 hours of laboratory instruction and 20 supervised cases that involve sedation or general anesthesia. The assistant may apply to take a secure exam which may qualify them for licensure as a dental sedation assistant (CCR 1070.8). The course requires completion of a minimum of 110 hours of education, over four times that required by any other state.

Approved training for sedation assistants in five states consists of the satisfactory completion of courses offered by professional associations such as the AAOMS or the ADSA that require approximately 24 hours of education. We were unable to identify any state that requires the presence of a registered nurse or other medical professional during sedation or anesthesia for dental treatment. We were unable to identify any state that requires the presence of an individual dedicated to both the monitoring and administration of anesthesia or sedation who is not involved in the procedure.

## **Facilities**

State laws specify facility requirements such as a treatment room of adequate size to accommodate the patient and three individuals, adequate lighting, a power operated chair or table, suction, a supply of oxygen, and appropriate backup systems to allow completion of a procedure in the event of a power failure. These requirements are relatively uniform for all states we reviewed.

## **Monitors and ancillary equipment**

State laws generally require the dentist to equip the treatment room with the appropriate patient monitors and to possess the ancillary equipment necessary to provide safe anesthesia and sedation. Required equipment varies depending on the level of sedation, with additional monitors such as the electrocardiogram (ECG), a defibrillator, and capnography usually required for general anesthesia but not for moderate or minimal sedation. California's requirements are consistent with those of other states as well as with the recommendations included in professional association guidelines.

## **Records**

State laws specify the records that must be maintained for sedation and anesthesia, including a time dependent record of pulse, blood pressure, oxygen saturation, ECG where appropriate, the doses of medications administered and the time they are given, and any complications.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Monitoring of exhaled carbon dioxide is an emerging trend , and this is now required in twenty (20) states not only for deep sedation and general anesthesia but also for moderate sedation. In California monitoring of exhaled CO<sub>2</sub> is mandatory only for patients who require endotracheal intubation.

## **Informed Consent**

A written consent form must be completed and signed by the patient, parent or legal guardian prior to the administration of anesthesia or sedation in California as well as other states.

## **Discharge**

State law requires an evaluation of the patient by a qualified person prior to discharge, and notation of their condition in the treatment record. California requires this evaluation notation as do most other states.

## **Drugs necessary for the treatment of medical emergencies**

State laws require the dentist to possess the drugs necessary for the treatment of medical emergencies and to have the knowledge and ability to use these drugs. The specific medications necessary for the management of sedation and anesthesia related emergencies are listed in the sedation laws of the majority of states, as well as in professional association guidelines. These include medications necessary for the treatment of allergic reactions, respiratory emergencies, cardiac conditions including cardiac arrest, diabetic conditions, high blood pressure, low blood pressure, and antidotes (reversal agents) for sedatives and narcotics . Medications for the treatment of malignant hyperthermia are required where appropriate. Additional medications are usually required when general anesthesia is administered as compared to moderate or minimal sedation. The medications required in California are consistent with those required in other states and recommended by professional association guidelines.

## **Office Inspections**

California, along with 37 other states, requires the state board to conduct an inspection of dental offices where moderate sedation and general anesthesia are given. Inspections are not usually required for offices where minimal sedation or nitrous oxide/oxygen alone are utilized. Dentists with permits for minimal or moderate enteral sedation are required to certify that they possess the specified equipment and emergency drugs and are capable of managing emergencies.

Facilities such as ambulatory care centers and hospitals where dental treatment may occur are usually accredited and licensed by other state agencies or accrediting organizations.



# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Most states require an inspection of dental offices by the board of dentistry every five (5) years. The inspection is either very similar to either the process utilized by the California Dental Board or the similar process described in the AAOMS Office Evaluation Manual . The office inspection requires two peer evaluators appointed by the board to inspect the facility, equipment, and emergency drugs. The evaluators must observe at least one clinical case performed by the dentist and his or her staff appropriate for the type of permit they possess. The inspection requires the dentist and his or her team to physically demonstrate the performance of up to thirteen (13) simulated emergencies. The simulated emergencies include airway obstruction, laryngospasm, bronchospasm, respiratory depression, scenarios that are widely recognized as being among the most significant complications of sedation and anesthesia. In addition the dentist and his or her team must demonstrate their skills in basic CPR and for general anesthesia permit holders advanced cardiac life support. This provides the evaluation team with an opportunity to assess the competency of sedation/anesthesia providers in their own facilities and with their own team members, including team dynamics, closed loop communication, and appropriate activation of emergency backup from first responders.

Inspections are usually graded on a pass fail basis and the results are reported for a final determination by the board. A failing grade requires the inspection to be repeated and a second failure usually results in denial of the permit to administer sedation or general anesthesia.

## **Pediatric sedation requirements**

States have taken differing approaches to the regulation of pediatric sedation. Twenty five states, including California have included special requirements for young patients. California requirements apply to patients age 13 or under. An increasing number of states have adopted pediatric sedation educational requirements and permits over the past 10 years.

Nine states (California, Colorado, Florida, Georgia, Kentucky, Louisiana, Missouri, Mississippi, and North Carolina) require a permit for sedating pediatric patients. Sixteen states require specific training to administer moderate/conscious sedation to pediatric patients. Twenty-five states have specific requirements for pediatric sedation administered by the oral route.

A number of states define the pediatric patient as under the age of 12 consistent with ADA Guidelines; however other states use 13, 14, 16 and 18 years of age. Most states, including California, specify that the practitioner must have appropriately sized equipment for pediatric patients. In most states ACLS certification is deemed sufficient for treating

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

pediatric patients; Twenty states currently require PALS certification. California does not presently require certification in PALS.

Although ten states have adopted the AAP-AAPD Guidelines, these apply to minimal and moderate sedation only in those states. We were unable to identify any state that requires an individual dedicated to monitoring and administration of deep sedation or general anesthesia for children or adults.

## **Utilization of CRNA's and MD Anesthesiologists**

All states allow anesthesia to be provided in dental offices by CRNA's and physician anesthesiologists. For some states it is difficult to determine the requirements for non-dentist anesthesia providers because they may be regulated by nursing and medical practice acts, not the dental practice act. The subcommittee felt that other professional practice acts were beyond the scope of this review.

Twenty nine states, including California, require a dentist who orders the administration of sedation or anesthesia by a CRNA to possess either a moderate sedation or general anesthesia permit issued by the board that corresponds to the level of sedation administered. A number of states, including California, require a physician anesthesiologist to obtain a permit from the Dental Board if they administer sedation or anesthesia in a dental office.

## **Summary**

**The subcommittee finds that California's laws and regulations for dentists providing general anesthesia and moderate sedation are generally consistent with laws in other states in the following areas:**

Areas of comparison

- Education
- Preoperative evaluation
- Facility
- Monitoring and Equipment
- Records
- Emergency Drugs
- Office inspection
- Pediatric and adult oral conscious sedation

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

## Permit types

- Minimal sedation
- Moderate enteral sedation
- Moderate parenteral sedation
- Deep Sedation/General Anesthesia

**The subcommittee finds that California's laws and regulations are differ from those in other states in the following areas:**

- Personnel
- Preoperative dietary instructions
- Pediatric moderate sedation (Pediatric Oral Conscious Sedation Permit)

## Discussion

- **Personnel**

California does not require the presence of a specific number of staff for general anesthesia and moderate sedation. Thirty three states specify that there be at least two persons be present, in addition to the dentist, when general anesthesia is administered, and thirty one states specify that at least one person be present when moderate sedation is administered.

In addition, twenty nine states require the presence of a designated anesthesia monitor. Fourteen states specify training requirements for the sedation monitor, usually completion of an educational program offered by a professional association such as the AAOMS or ADSA.

- **Preoperative dietary instructions**

California does not presently require that instructions for pre operative fasting be given. Approximately ten states require instructions based on the planned level of sedation similar to those described in the ADA Guidelines. The ADA Guidelines recommend that preoperative dietary restrictions be considered based on the sedative technique prescribed. Some states require instructions that are consistent with those for general anesthesia, usually according to the "2-4-6" rule, with no oral intake for 2 hours prior to sedation for liquids, 4 hours for breast milk, and 6 hours for solids.

- **Pediatric sedation**

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Although thirty three states have requirements for dentists who administer pediatric sedation, these vary, ranging from completion of a PALS course to completion of an advanced residency education program in pediatric dentistry. Requirements usually include training in pediatric oral sedation similar to California. Ten states, including California, issue a permit to dentists who administer sedation to children under thirteen, most often for moderate parenteral sedation.

## **Professional Dental Association Guidelines, Position Papers and Policy Statements**

The dictionary definition of “guideline” is “general rule, principle, or piece of advice.” Guidelines come in the form of “Statements,” “Practice Advisories,” “Clinical Policies,” or “Recommendations.” These documents range from broad descriptions of appropriate monitoring and treatment to those offering specific guidelines on the use of particular drugs or techniques. The guidance documents we reviewed were developed by professional associations.

The subcommittee’s charge is to review state laws and association policies from the dental profession, not the medical profession. Due to requests from stakeholders we will address requests from all interested parties including the American Academy of Pediatrics and the California Society of Anesthesiologists.

Guidelines and position papers reviewed include:

- American Dental Association *“Guidelines for Use of Sedation and General Anesthesia By Dentists”*
- American Academy of Pediatrics-American Academy of Pediatric Dentistry *“Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures”* .
- American Academy of Pediatrics *“Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures”*
- American Society of Anesthesiology – *“ Standards for Basic Anesthetic Monitoring”*. Oct 2015.
- ASA *“Statement on the Anesthesia Care Team”*
- ASA *“Statement on Granting Privileges to Non-Anesthesiologist Physicians for Personally Administering or Supervising Deep Sedation”*
- American Dental Association *“Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students”*

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

- American Society of Anesthesiology: *“Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists”*.
- American Society of Anesthesiology: *“Advisory on Granting Privileges for Deep Sedation to Non-Anesthesiologists Sedation Providers.”*

The Center for Medicare and Medicaid Services (CMS) includes dentists among practitioners who are authorized to administer anesthesia under the *Hospital Anesthesia Services Condition of Participation 42 CFR 482.52(a)*. CMS Conditions of Participation are federal regulations that describe the health and safety requirements for hospitals and ambulatory surgery centers that participate in the Medicare and Medicaid programs.

The American Academy of Pediatrics submitted the “Guidelines for Monitoring and Management of Pediatric Patients Before, during and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016” for review. This document is fundamentally the same document adopted by the American Academy of Pediatric Dentistry and will therefore not be addressed separately. As previously noted, The California Society of Anesthesiologists submitted three documents for review.

Guidelines for general anesthesia and sedation utilized by dentists are published by the American Dental Association (ADA) as the “Guidelines for Use of Sedation and General Anesthesia By Dentists” and “Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students”. For children 12 years of age and under, the American Dental Association supports the use of the “American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures” (AAP-AAPD Guidelines)<sup>16</sup>. These guidelines are directed toward all dentists treating children and are not limited to members of specialty organizations or specific professional associations. Both the ADA and the AAP-AAPD Guidelines are currently undergoing revision.

---

<sup>16</sup> American Academy of Pediatric Dentistry, “American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures”, adopted 2006, affirmed 2011.

[http://www.aapd.org/media/Policies\\_Guidelines/G\\_Sedation.pdf](http://www.aapd.org/media/Policies_Guidelines/G_Sedation.pdf)

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Guidance documents are also published by dental specialty associations, including the American Association of Oral and Maxillofacial Surgeons and the American Society of Dentist Anesthesiologists, that are directed to their members.<sup>17 18</sup>

State dental associations such as the California Dental Association usually incorporate American Dental Association documents by reference into their own guidance documents and do not develop their own, however there are exceptions such as Pennsylvania.

The methodologies used to develop guidelines vary from organization to organization. For example, The American Dental Association Guidelines for the Use of Sedation and Anesthesia by Dentists and the American Academy of Pediatrics – American Association of Pediatric Dentists Guidelines are based on a careful consideration of the available literature and expert opinion. The exact nature of how studies were weighted and how conclusions were drawn is not explicitly described.

## **Guideline development process**

There are many publications that describe the clinical guideline development process and full discussion of this topic is beyond the scope of this report. To summarize, the process begins by defining a clinical question. Related evidence is identified through a systematic review of the scientific literature. The quality of evidence is assessed and data are extracted and classified according to the strength of the evidence. When there is insufficient evidence expert opinion is used as a basis for recommendations, however opinion is usually given less weight than results of studies and opinion may be subject to bias. There is currently no optimal process for the assessment of opinion, and the process utilized should be as explicit as possible. In addition to scientific evidence and expert opinion, guidelines must take into account resource implications and the feasibility of interventions. Judgments about whether the costs of tests or treatment are reasonable may depend on the perspective taken, for example clinicians may view cost considerations differently than would payers or the public. Feasibility issues include time, skills staff and equipment necessary for the provider to carry out the recommendations,

---

<sup>17</sup> AAOMS. (2012). Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial SurgMSery (AAOMS ParCare 2012).

<sup>18</sup> American Society of Dentist Anesthesiologists. (2013). American Society of Dentist Anesthesiologists Parameters of Care The Continuum of Sedation and Anesthesia, 1–13.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

and the ability of the system of care to implement them.<sup>19</sup> None of the guidelines we reviewed addressed resource considerations or feasibility considerations.

## **American Dental Association Guidelines**

The ADA *Guidelines for the Use of Sedation and General Anesthesia by Dentists* and the *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (Sedation and Anesthesia Guidelines) are policy of the ADA and receive final approval by the ADA House of Delegates.

According to the ADA Constitution and Bylaws, the Council on Dental Education and Licensure (CDEL) has subject matter authority for dental anesthesiology and sedation and recommends

Delegates as the final authority. CDEL's Anesthesiology Committee, comprised of seven sedation and anesthesiology experts and chaired by a CDEL member, develops recommendations for CDEL's consideration using available literature, policies and guidelines of other national health care organizations and expert opinion. All proposed revisions of the Sedation and Anesthesia Guidelines are circulated to anesthesiology communities of interest; comments are invited from any individual or organization.

## **American Academy of Pediatric Dentistry Guidelines**

The AAPD's guideline development process is outlined in an overview statement outlined in their reference manual posted on their website.<sup>20</sup> Guidelines are defined as:

*"Systematically developed recommendations designed to assist the practitioner, patient, and caregiver in making decisions relating to specific clinical situations. Guidelines are intended to be more flexible than standards. Guidelines should be followed in most cases, but they recognize that treatment can and should be tailored to fit individual needs, depending on the patient,*

---

<sup>19</sup> Shekelle, P. G., Woolf, S. H., Eccles, M., & Grimshaw, J. (1999). Clinical guidelines: developing guidelines. *BMJ (Clinical Research Ed.)*, 318(7183), 593–596. <http://doi.org/10.1136/bmj.318.7183.593>

<sup>20</sup> American Academy of Pediatric Dentistry. (2011). Definitions and scope of pediatric dentistry. *Reference Manual*, 33(6), 2–349. Retrieved from [http://www.aapd.org/media/Policies\\_Guidelines/Intro1.pdf](http://www.aapd.org/media/Policies_Guidelines/Intro1.pdf).

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

*practitioner, setting, and other factors. Deviations from guidelines could be fairly common and could be justified by differences in individual circumstances. Guidelines are designed to produce optimal outcomes, not minimal standards of practice.”*

The AAPD Council on Clinical Affairs (CCA) is charged with the development of oral health policy guidelines. Oral health policies and clinical guidelines utilize two sources of evidence: the scientific literature and experts in the field. CCA, in collaboration with the Council on Scientific Affairs, performs a comprehensive literature review for each document. When scientific data do not appear conclusive, experts may be consulted. The CCA’s recommendations are submitted to AAPD’s Board of Trustees for review, with eventual approval at the AAPD’s General Assembly. It is unclear whether input is solicited from non member dentists, outside organizations or the public. Detailed information is available to AAPD members only. AAP-AAPD draft guidelines are subsequently forwarded to the American Academy of Pediatrics for endorsement and are then published as a joint document.

The AAP-AAPD Guidelines were last submitted to the ADA House of Delegates for consideration in 2012. The ADA House of delegates voted to support the AAP-AAPD Guidelines for the dental treatment of children under twelve. This approach to policy for the treatment of children has been utilized by the ADA for many years.

Guidelines of the American Society of Anesthesiologists (ASA) and American College of Emergency Physicians (ACEP) are founded on an evidence based review of the sedation literature and the methodologies are quite explicit. Even in these cases the lack of definitive or comparative data on outcomes of sedation necessitate that many of the guidelines are based on “consensus” rather than “evidence”.<sup>21</sup>

The American Society of Anesthesiology (ASA) represents approximately 35,000 practicing anesthesiologists in the United States . Anesthesiology is recognized as a leading specialty of medicine in the field of patient safety research, particularly as it relates to sedation and general anesthesia. Sedation guidance documents in all branches of the healing arts are heavily influenced by standards and guidelines established by ASA.

The ASA periodically publishes guidance documents on a wide variety of topics related to sedation and anesthesia . The ASA Committee on Standards and Practice Parameters, other ASA committees, and task forces periodically collect evidence to determine whether new or existing practice guidelines are needed. The Committee develops these documents, which are

---

<sup>21</sup> Cravero, J.P: Sedation Policies, Recommendations and Guidelines Across the Specialties and Continents. In, K.P. Mason (ed.), *Pediatric Sedation Outside of the Operating Room: A Multispecialty International Collaboration*, 17.DOI 10.1007/978-1-4939-1390-9\_2, © Springer Science+Business Media New York 2015



# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

then approved by a vote of the ASA membership at the ASA House of Delegates annual meeting.

**ASA Standards, Guidelines, Statements and Practice Parameters**<sup>22</sup> provide guidance to improve decision-making and promote beneficial outcomes for the practice of anesthesiology. They are not intended as unique or exclusive indicators of appropriate care. The interpretation and application of Standards, Guidelines and Statements takes place within the context of local institutions, organizations and practice conditions. A departure from one or more recommendations may be appropriate if the facts and circumstances demonstrate that the rendered care met the physician's duty to the patient.

**Standards** provide rules or minimum requirements for clinical practice. They are regarded as generally accepted principles of patient management. Standards may be modified only under unusual circumstances, e.g., extreme emergencies or unavailability of equipment.

**Guidelines** are systematically developed recommendations that assist the practitioner and patient in making decisions about health care. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies. In addition, practice guidelines are not intended as standards or absolute requirements, and their use cannot guarantee any specific outcome. Practice guidelines are subject to revision as warranted by the evolution of medical knowledge, technology, and practice. They provide basic recommendations that are supported by a synthesis and analysis of the current literature, expert opinion, open forum commentary, and clinical feasibility data.

**Statements** represent the opinions, beliefs, and best medical judgments of the House of Delegates. As such, they are not necessarily subjected to the same level of formal scientific review as ASA Standards or Guidelines. Each ASA member, institution or practice should decide individually whether to implement some, none, or all of the principles in ASA statements based on the sound medical judgment of anesthesiologists participating in that institution or practice.

**Practice parameters** provide guidance in the form of requirements, recommendations, or other information intended to improve decision-making and promote beneficial outcomes for the practice of anesthesiology. The use of practice parameters cannot guarantee any specific outcome. Practice parameters are subject to periodic revision as warranted by the evolution of

---

<sup>22</sup> American Society of Anesthesiologists. Resources, Clinical information, <https://www.asahq.org/resources/clinical-information>, accessed 7/7/2016.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

medical knowledge, technology and practice. Variance from practice parameters may be acceptable, based upon the judgment of the responsible anesthesiologist.

**Practice advisories** are systematically developed reports that are intended to assist decision-making in areas of patient care. Advisories provide a synthesis and analysis of expert opinion, clinical feasibility data, open-forum commentary, and consensus surveys. Practice Advisories developed by the American Society of Anesthesiologists (ASA) are not intended as standards, guidelines, or absolute requirements, and their use cannot guarantee any specific outcome. They may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies.

Practice Advisories are not supported by scientific literature to the same degree as standards or guidelines because of the lack of sufficient numbers of adequately controlled studies. Practice Advisories are subject to periodic update or revision as warranted by the evolution of medical knowledge, technology, and practice.

We reviewed three documents submitted by the California Society of Anesthesiologists, including :

- *Statement on Granting Privileges to Non-Anesthesiologist Physicians for Personally Administering or Supervising Deep Sedation*<sup>23</sup>
- *The ASA Statement on the Anesthesia Care Team*
- *ASA Standards for Basic Anesthesia Monitoring.*

We reviewed the following definitions published by the ASA that apply to these statements.<sup>24</sup>

1.1 Anesthesia Professional: An anesthesiologist, anesthesiologist assistant (AA), or certified registered nurse anesthetist (CRNA).

1.2 Non-anesthesiologist Sedation Practitioner: A licensed physician (allopathic or osteopathic); or dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; who has

---

<sup>23</sup>

<sup>24</sup> American Society of Anesthesiologists. (2010). Advisory on granting privileges for deep sedation to non-anesthesiologist sedation practitioners. Retrieved from <http://www.asahq.org/~media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/advisory-on-granting-privileges-for-deep-sedation-to-non-anesthesiologist.pdf>

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

not completed postgraduate training in anesthesiology but is specifically trained to administer personally or to supervise the administration of deep sedation.

- 1.3 Unrestricted general anesthesia shall only be administered by anesthesia professionals within their scope of practice (anesthesiologists, certified registered nurse anesthetists and anesthesiologist assistants).

## **National Guidelines Clearinghouse**

The U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality hosts the National Guidelines Clearinghouse . The Clearinghouse maintains a database of guidelines that must meet inclusion standards. Clinical practice guidelines must be submitted by a medical specialty association, relevant professional society, government, or healthcare organization and must be based on a systematic review of evidence that is intended to assist practitioners and patients with decisions for specific clinical circumstances.<sup>25</sup> None of the professional association guidance documents we reviewed are listed by the Clearinghouse. It is unclear whether or not they met inclusion criteria or were submitted for consideration by the Clearinghouse.

## **Discussion**

We provide a side by side comparison table of California's dental sedation laws, the American Dental Association Guidelines and the AAP-AAPD Guidelines as Appendix 2. Although these guidelines are not recognized by all states they come close to establishing national parameters for sedation and anesthesia care for the dental profession. Other professional dental association guidelines include similar information that appears to be directed toward a specific association membership. The following guidance documents are provided for reference but are not included in the comparison tables.

1. American Association of Oral and Maxillofacial Surgeons, Parameters of Care, Clinical Guidelines
2. American Society of Dentist Anesthesiologists Parameters of Care

**Comparison tables to show differences and similarities between California laws and the ADA and AAP-AAPD Guidelines are organized by topic. Please see Appendix 2, Tables 1-10.**

---

<sup>25</sup> Inclusion Criteria, National Guideline Clearinghouse, <https://www.guideline.gov/about/inclusion-criteria.aspx>

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

## Area of comparison

- Definitions Table 1
- Education - Table 2
- Preoperative evaluation – Table 3
- Personnel - Table 4
- Facility – Table 5
- Monitoring and Equipment – Table 6
- Records – Table 7
- Emergency Drugs – Table 8
- Office inspection – Table 9
- Preoperative dietary instructions – see Table 3

## Summary

**Areas where California requirements are consistent with professional guidance documents include:**

- **Preoperative evaluation**
- **Facility**
- **Monitoring and equipment**
- **Records**
- **Emergency drugs**
- **Office inspection**

**Areas where California requirements are different:**

- **Monitoring**
- **Personnel**
- **Education**
- **Preoperative fasting**

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

## Discussion

The ADA Guidelines are prescriptive and state which monitors should be used for each level of sedation. The ASA Standards for Basic Anesthetic Monitoring use a similar approach.<sup>26</sup>

The ADA guidelines specify that ECG monitoring should be considered during moderate sedation for patients with cardiovascular disease and that use of the ECG is required for patients receiving general anesthesia. They also state when an intravenous line must be established, and how ventilation and respiration are monitored.

In contrast, California law states the dentist must possess the necessary equipment, but leaves the use of the equipment to the discretion of the dentist. The use of a pulse oximeter is required for all levels of sedation. California law specifies the records that must be maintained and specifies the recording intervals for vital signs. It would be impossible for the dentist to maintain the required records without monitoring, therefore adding a specific monitoring requirement for vital signs and pulse oximetry might be considered redundant. Capnography is required for intubated general anesthesia only which is consistent with ADA guidelines. ASA monitoring standards indicate capnography is required for all patients undergoing sedation or anesthesia.

The AAP-AAPD Guidelines follow a similar approach to that used by California and list the drugs and equipment that should be present and available and which records should be maintained, but does not state which monitors or techniques must be used. California law is consistent with AAP- AAPD Guidelines in this area.

The ASA *“Statement on Granting Privileges to Non-Anesthesiologist Physicians for Personally Administering or Supervising Deep Sedation”* includes the following language:

*“Nonanesthesiologist physicians may neither delegate nor supervise the administration or monitoring of deep sedation by individuals who are not themselves qualified and trained to administer deep sedation, and the recognition of and rescue from general anesthesia.”*

California law permits delegation of limited monitoring duties to dental assistants, but does not permit delegation of the administration of sedation or anesthesia other than nitrous oxide and oxygen, except as otherwise allowed by law. ( see Business and Profession Code 1750.1(f).

---

<sup>26</sup> American Society of Anesthesiology. Standards for Basic Anesthetic Monitoring. Oct 2015.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Trained and licensed assistant may assist with sedation or anesthesia as specified. ADA Guidelines and AAP-AAPD Guidelines also describe the role of personnel who may monitor moderate sedation as well as deep sedation/general anesthesia, although the qualifications of these personnel are not specifically addressed, but must be appropriately trained and qualified.

The *ASA Statement on the Anesthesia Care Team* indicates that although the Anesthesia Care Team may include non-physicians, the Team should be directed by an anesthesiologist.

California law does not presently require the presence of an anesthesiologist in a dental office where anesthesia is given and authorizes dentists who hold a general anesthesia permit to administer deep sedation/general anesthesia. The AAP-AAPD Guidelines address the administration of deep sedation and general anesthesia in dental facilities such as dental offices through a description of the necessary skills and qualifications. For facilities that function under a department of anesthesiology the AAP-AAPD guidelines defer to the ASA policies implemented by the department.

The *ASA Standards for Basic Anesthesia Monitoring* describe which monitors should be used for the different levels of sedation and general anesthesia, and indicate that there should be continuous monitoring with and ECG, pulse oximeter, capnograph and blood pressure recorded every five minutes.

Current California law requires continuous pulse oximetry for all levels of sedation and anesthesia. Although an ECG must be available for dentists who administer general anesthesia, its use is not required. Vital signs must be recorded at 5 minute intervals. Dentists who administer moderate sedation are not required to possess or use an ECG or capnograph, and must record vital signs at regular intervals. The ADA Guidelines specify continuous ECG monitoring for patients receiving deep sedation or general anesthesia but do not indicate mandatory use of capnography except for intubated patients or those receiving volatile agents. The AAP-AAPD Guidelines indicate that monitors must be available.

## **Education**

California's educational requirements for moderate sedation, adult and pediatric oral conscious sedation (OCS), conscious sedation, and general anesthesia permits are consistent with the ADA Guidelines but differ from the corresponding ADA educational guidelines in several areas. See Table 2 for a side by side comparison.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

- Adult oral conscious sedation permits - California law requires one patient experience. ADA Guidelines recommends three patient experiences.
- Pediatric sedation - In California there are specific training requirements for the Oral Conscious Sedation for Minors permit. The ADA Guidelines specify that additional experience should be required for sedating pediatric patients.
- California does not have age specific requirements for sedation administered via parenteral routes or for pediatric deep sedation/general anesthesia. The ADA and AAP-AAPD also do not provide specific pediatric sedation training requirements and defer to CODA accreditation standards for advanced education.
- California law does not require completion of PALS for dentists who sedate pediatric patients. The value of the PALS course for sedation providers may be limited. A course dedicated to pediatric sedation that focuses on airway management, preferably with a patient simulator component, may be more appropriate.

## Personnel

California does not require that a specific number of staff be present for general anesthesia or moderate sedation, however this is well established as a community practice standard. Both the ADA and AAP-AAPD Guidelines specify that there be two persons present in addition to the dentist for general anesthesia or deep sedation, and at least one other person for sedation. The AAP-AAPD Guidelines specify the presence of one person whose only responsibility is to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation and to either administer drugs or direct their administration, for deep sedation/general anesthesia. California, like other states, does not have specific requirements for pediatric deep sedation or general anesthesia other than possession of a general anesthesia permit.

## Preoperative dietary instructions

- California does not specify that preoperative dietary instructions be given. ADA Guidelines state that dietary precautions should be considered based on the sedative technique prescribed. The AAP-AAPD Guidelines include the following statement:
- *“the practitioner should evaluate preceding food and fluid intake, ....but because the absolute risk of aspiration during procedural sedation is not yet known, guidelines for fasting periods before elective sedation generally should follow those used for elective general anesthesia. For emergency procedures in children who have not fasted, the risks of sedation and the possibility of aspiration must be balanced against the benefits of performing the procedure promptly. Further*

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

*research is needed to better elucidate the relationships between various fasting intervals and sedation complication”.*

- The 2016 draft ADA guidelines incorporate the ASA Practice Guidelines on Preoperative Fasting by reference.<sup>27</sup>

## **Literature Review - Sedation and General Anesthesia for Pediatric Dental Patients**

The published literature on pediatric sedation and anesthesia is extensive and a comprehensive review is beyond the scope of this assignment. This section should be considered an overview, not an in depth analysis of the available literature.

We considered a number of approaches to a literature review, including an evidence based systematic review. The subcommittee found that recent systematic reviews of the pediatric sedation literature have been completed, although not in the United States.<sup>28</sup> Because there is insufficient evidence to support recommendations for some aspects of pediatric sedation most guidance documents must also rely on a consensus of opinion. This reduces the strength of certain recommendations. Controversies nearly always involve differences of opinion that are unlikely to be resolved by additional systematic reviews.

### **Search strategy**

The subcommittee conducted an electronic literature search in of the Medline, Cochrane Library, and DOSS EBSCO databases. Search terms included safety, morbidity, mortality, complications, moderate sedation, deep sedation, general anesthesia and dental offices; Fields: all; Limits; within the last 10 years, humans, all children from birth through age 21, language: English; clinical trials and literature reviews.

---

<sup>27</sup> American Society of Anesthesiologists Committee on standards and practice parameters. (2011). Practice guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures: an updated report by the American Society of Anesthesiologists Com. *Anesthesiology*, 114(3), 495–511. <http://doi.org/10.1097/ALN.0b013e3181fcbfd9>

<sup>28</sup> National Clinical Guideline Center. (2010). Sedation in children and young people. National Institute for Clinical Excellence, Royal College of Surgeons, London.



# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

The subcommittee selected articles judged to be relevant pediatric dental sedation safety within the United States healthcare system. Articles on local anesthesia, nitrous oxide and minimal sedation were excluded. In an effort to reduce risk of bias we requested references from stakeholders and interested parties. Additional articles were obtained by reviewing references. Selected articles with abstracts were downloaded into a reference manager. We obtained full text versions of the most relevant articles which are provided as references for this report.

## **Anesthesia outcomes research - See Figure 1**

Anesthesia outcomes research has undergone considerable evolution over time. Although randomized trials remain the gold standard for clinical evidence, results obtained from such efficacy trials often generalize poorly. Furthermore, conventional randomized trials are limited in that mortality and other serious complications are usually too rare to practically address. There is thus increasing interest in clinical effectiveness studies in which interventions are evaluated over an entire health care environment. Researchers from the Anesthesia Outcomes Consortium at the Cleveland Clinic are presently utilizing innovative randomized effectiveness studies in which decision support systems, combined with electronic anesthesia records are utilized.<sup>29</sup> Cravero and others have reported the development of an integrated outcome database for pediatric anesthesia which holds great promise for the future.<sup>30</sup>

## **Pediatric sedation studies**

Review articles identify very few high quality published reports and clinical trials related to pediatric sedation for dentistry.<sup>31</sup><sup>32</sup> This may be due to the practical difficulties of enrolling sufficient number of children into adequately controlled and blinded studies.

---

<sup>29</sup> Kurz A, Sessler D. outcomes research. HSR Proceedings in Intensive Care and Cardiovascular Anesthesia 2012; 4 (1): 5-9.

<sup>30</sup> Cravero JP, Sriswasdi P, Lekowski R, Carpino E, Blum R, Askins N, Zurakowski D, Sinnott S. Creation of an integrated outcome database for pediatric anesthesia. Paediatr Anaesth. 2016 Apr;26(4):345-55. doi: 10.1111/pan.12857.

<sup>31</sup> Mittal, N., Goyal, A., Jain, K., & Gauba, K. (2015). Pediatric Dental Sedation Research: Where Do We Stand Today? *J Clin Pediatr Dent*, 39(3), 284–291. <http://doi.org/10.17796/1053-4628-39.3.284>

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Ashley et al have published one of the few systematic reviews of pediatric dental sedation, and stated that they found no randomized controlled trials that compared sedation to general anesthesia for pediatric dentistry.<sup>33</sup> Lourenco-Matharu et al, in their systematic review, were able to find weak evidence of the effectiveness of midazolam, but identified few if any high quality pediatric sedation studies.<sup>34</sup>

Lee<sup>35</sup> noted that the study of the safety of pediatric dental anesthesia has been limited. Although there are a number of reports of serious injury or death related to pediatric dental anesthesia, there is also a lack of systematic research in this area. Because significant anesthesia injury is a relatively rare occurrence, it is difficult to study prospectively or by retrospective medical record review, even when data is collected from multiple institutions.

## Anesthesia morbidity and mortality data

Morbidity and mortality figures have been used to determine patient risk and, hence, have played a prominent role in establishing malpractice premiums and in efforts to legislate the practice of sedation and general anesthesia in dentistry.<sup>36</sup> Though it is important to know the frequency of these events, their incidence can be misleading, because the numbers do not describe the events. Questions concerning characteristics of the patients, the practitioners, drugs used, patient monitoring, and resuscitative efforts remain obscure. Thus, incidence figures cannot explain why morbidity and mortality occurs, nor how to prevent it. For example, do these events represent acute hypersensitivity reactions of healthy patients in the hands of

---

<sup>32</sup> Ashley, P. F., Williams, C. E., Moles, D. R., & Parry, J. (2015). Sedation versus general anaesthesia for provision of dental treatment to patients younger than 18 years. *Cochrane Database Syst Rev*, 9, Cd006334. <http://doi.org/10.1002/14651858.CD006334.pub4>

<sup>33</sup> Ashley, P. F., Williams, C. E., Moles, D. R., & Parry, J. (2015). Sedation versus general anaesthesia for provision of dental treatment to patients younger than 18 years. *Cochrane Database Syst Rev*, 9, Cd006334. <http://doi.org/10.1002/14651858.CD006334.pub4>

<sup>34</sup> Lourenco-Matharu, L., Ashley, P. F., Furness, S., Lourenco-Matharu, L., PF, A., & Furness, S. (2012). Sedation of children undergoing dental treatment. *Cochrane Database of Systematic Reviews*, 3(3), N.PAG–N.PAG 1p. <http://doi.org/10.1002/14651858.CD003877.pub4>

<sup>35</sup> Lee, H. H., Milgrom, P., Starks, H., & Burke, W. (2013). Trends in death associated with pediatric dental sedation and general anesthesia. *Paediatr Anaesth*, 23(8), 741–746. <http://doi.org/10.1111/pan.12210>

<sup>36</sup> Krippaehne, J. A., & Montgomery, M. T. (1992). Morbidity and mortality from pharmacosedation and general anesthesia in the dental office. *Journal of Oral and Maxillofacial Surgery*. [http://doi.org/10.1016/0278-2391\(92\)90099-L](http://doi.org/10.1016/0278-2391(92)90099-L)

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

practitioners performing proficiently or do they result from the negligent efforts of incompetent professionals? Answers to these questions are as important as incidence data for judging safety, assessing patient risk, and for determining the need and direction of future legislative efforts.

We reviewed anesthesia morbidity and mortality studies of the general and pediatric populations because pediatric morbidity and mortality is thought to represent a subset of adult morbidity and mortality, although there are important differences. Li et al<sup>37</sup> provide recent estimates of anesthesia mortality risk based on studies conducted in Europe, Japan, and Australia. They hypothesize that the paucity of anesthesia mortality studies in the United States in recent years is compounded by several factors. First, improvement in anesthesia safety has made anesthesia-related deaths rare events; and studying rare events usually requires large sample sizes and considerable resources. Second, there is not an established national surveillance data system for monitoring anesthesia mortality. Lastly, clinical practice of anesthesia has expanded so much that it is extremely difficult to gather exposure data. It is estimated that most surgical anesthesia procedures are now performed in ambulatory care settings. The use of anesthesia for therapeutic and diagnostic purposes is also on the rise.

A systematic review of Brazilian and worldwide literature<sup>38</sup> provides a summary of the studies of mortality incidence of pediatric patients who underwent anesthesia in developed countries between 2001 and 2011. This review reports mortality as 0.41-13.4 per 10,000 hospital discharges. Major risk factors include age < 1 year old, ASA III or higher physical status, emergency surgery, general anesthesia and cardiac surgery. Although this report reviewed outcomes from all ASA levels the authors note although rare, anesthesia related mortality still occurs in ASA physical status I-II children.

We searched for studies that reported outcomes for relatively healthy patients because dentists are more likely to provide office sedation and anesthesia to ASA I and II patients. A recent report by Schiff<sup>39</sup> provides anesthesia related mortality statistics from the first study to

---

<sup>37</sup> Li G, Warner M, Lang BH, Huang L, Sun LS. [Epidemiology of anesthesia-related mortality in the United States, 1999-2005](#). *Anesthesiology*. 2009 Apr;110(4):759-65. PubMed PMID: 19322941; PubMed Central PMCID: PMC2697561.

<sup>38</sup> Gonzalez, L., Pignaton, W., Kusano, P., Modolo, N., Braz, J., & Braz, L. (2012). Anesthesia-related mortality in pediatric patients: a systematic review. *Clinics*, 67(4), 381–387. [http://doi.org/10.6061/clinics/2012\(04\)12](http://doi.org/10.6061/clinics/2012(04)12).

<sup>39</sup> Schiff, J. H., Welker, A., Fohr, B., Henn-Beilharz, A., Bothner, U., Van Aken, H., ... Heinrichs, W. (2014). Major incidents and complications in otherwise healthy patients

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

utilize a standardized national tracking data base that allows calculation of the total number of cases, a “denominator”, that is not available from closed claims data. This study reports outcomes for 1,374,678 patients, including ASA I and II patients undergoing elective surgery in secondary hospitals, and indicates that risk of death or a serious complication from anesthesia is approximately 10 per million anesthetics.

A 1989 Harvard study<sup>40</sup> reported ASA I-II anesthetic related deaths, following implementation of improved monitoring standards, to be 1:244,000, but due to study limitations the data was not statistically significant. Lagasse<sup>41</sup> includes a review of published research related to anesthesia mortality prior to 1999 and reports similar findings.

The authors of these studies caution the reader that there is no standardized definition of anesthesia related mortality, and that this determination often relies on subjective interpretation of various definitions. Differences in methodology make it difficult to compare mortality rates among different studies because the mortality rate may depend on the surgical population being studied.<sup>42</sup> Although these studies do not support a firm conclusion, they suggest that anesthesia related mortality for ASA I and II patients treated in inpatient facilities may be in the range of 1:100,000 - 1:250,000.

---

undergoing elective procedures: Results based on 1.37 million anaesthetic procedures. *British Journal of Anaesthesia*, 113(1), 109–121. <http://doi.org/10.1093/bja/aeu094>

<sup>40</sup> Eichhorn JH. Prevention of intraoperative anesthesia accidents and related severe injury through safety monitoring. *Anesthesiology*. 1989 Apr;70(4):572-7. PubMed PMID: 2929993.

<sup>41</sup> Lagasse, R. S. (2002). Anesthesia safety: model or myth? A review of the published literature and analysis of current original data. *Anesthesiology*, 97(6), 1609–1617. <http://doi.org/10.1097/00000542-200212000-00038>

<sup>42</sup> Gonzalez, L., Pignaton, W., Kusano, P., Modolo, N., Braz, J., & Braz, L. (2012). Anesthesia-related mortality in pediatric patients: a systematic review. *Clinics*, 67(4), 381–387. [http://doi.org/10.6061/clinics/2012\(04\)12](http://doi.org/10.6061/clinics/2012(04)12)

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

## Office based surgery and anesthesia outcomes

We searched for reports of anesthesia safety data from office based facilities because dental treatment is usually provided in the office setting. Shapiro<sup>43</sup> reports a lack of randomized controlled trials that have measured morbidity and mortality in office based surgery and office based medical procedures. However there are numerous retrospective studies that compare morbidity and mortality outcomes in office, hospital, and ASC settings. The author concludes that much of the available literature confirms that there is a low rate of complications during office-based procedures and that risk in office based surgery is similar to other ambulatory settings.

Results from outcome studies of office based surgery usually include complications from surgical procedures, including cosmetic procedures such as liposuction and abdominoplasty with liposuction. These procedures are associated with death from pulmonary embolism and other complications not usually encountered with dental procedures. Data from the AAAASF quality assurance program included over a million outpatient procedures from 2001-2006 and reported a mortality rate of 0.002%.<sup>44</sup> Thirteen of 23 deaths were caused by pulmonary embolism. Studies of office based cosmetic procedures emphasize that there is inherent risk related to certain office based cosmetic procedures that should not be generalized to office based surgery in general.

Much of the knowledge related to anesthesia safety in the ambulatory setting stems from the American Society of Anesthesiologists' (ASA) Closed Claims Database. The ASA Closed Claims Project is described in a subsequent section of this report.

## Pediatric Dental Anesthesia Safety Research – See Figure 2

Our search identified only a handful of studies of anesthesia safety related to pediatric dentistry. One of the best known studies addressed complications of pediatric sedation through critical incident analysis. This study reported that 29% of adverse events were related

---

<sup>43</sup> Shapiro, F. E., Punwani, N., Rosenberg, N. M., Valedon, A., Twersky, R., & Urman, R. D. (2014). Office-based anesthesia: Safety and outcomes. *Anesthesia and Analgesia*, 119(2), 276–285. <http://doi.org/10.1213/ANE.0000000000000313>

<sup>44</sup> Keyes GR, Singer R, Iverson RE, McGuire M, Yates J, Gold A, Reed L, Pollack H, Thompson D. Mortality in outpatient surgery. *Plast Reconstr Surg* 2008;122:245–50

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

to dental treatment.<sup>45</sup> The study utilized a panel of four physicians who reviewed 118 reports of adverse sedation events from the FDA adverse event reporting system accumulated between 1969 and 1996, which yielded 51 reports of deaths, 9 cases of permanent neurological injury, and 21 cases of prolonged hospitalization without injury. Additional data was collected from USP adverse events and surveys of pediatric anesthesiologists, intensivists and emergency specialists. Patients were age < 20 years. Cases where general anesthesia or MAC (sedation) was performed by an anesthesiologist were excluded. Inadequate resuscitation, death and permanent neurological injury were more frequent in non-hospital based facilities. As with other studies, presenting events included respiratory events such as desaturation, apnea and laryngospasm with cardiac arrest occurring as a second or third event. The majority of patients were age 6 or less. Causes or contributing factors included drug related events, inadequate monitoring, inadequate resuscitation, and inadequate medical evaluation. The authors recommend improved insurance coverage for dental anesthesia, better training for dentists who use sedation, development of specialty independent guidelines and better regulation of facilities.

This report does not include an estimate of the incidence or prevalence of dental sedation/anesthesia morbidity and mortality. It includes data from a period approximately 27 years . During this time period there have been significant improvements in anesthesia safety and the results may not indicate outcomes from more recent practice.

Lee<sup>46</sup> reported a review of media reports of pediatric deaths related to dental treatment of 44 patients between 1980 and 2011, for patients up to age 21. The majority of deaths occurred between ages 2-5 (46.7%) and 13-21 (29.6%). The majority of deaths occurred in the office setting , the most common treatment location for general dentists, with the majority (45.5%) being related to moderate sedation, 22.7 % relate to general anesthesia and 22.7% not reported. The authors comment that it is not possible to evaluate the incidence and prevalence of pediatric sedation adverse outcomes without establishing an appropriate database.

---

<sup>45</sup> Cote, C. J., Notterman, D. A., Karl, H. W., Weinberg, J. A., & McCloskey, C. (2000). Adverse sedation events in pediatrics: a critical incident analysis of contributing factors. *Pediatrics*, 105(4 Pt 1), 805–814.

<sup>46</sup> Lee, H. H., Milgrom, P., Starks, H., & Burke, W. (2013). Trends in death associated with pediatric dental sedation and general anesthesia. *Paediatr Anaesth*, 23(8), 741–746. <http://doi.org/10.1111/pan.12210s>

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

The dental profession has published numerous studies of outcomes from sedation and anesthesia. Early epidemiological reports were based primarily on retrospective data, voluntary surveys of professional association members, with small sample sizes making them of limited value. These studies are well known and will not be repeated here. Other studies we reviewed were reports of specific drug combinations and techniques that utilized sample sizes of a few hundred patients from a single site. Again we felt these were of limited value.

Perrott<sup>47</sup> et al reported results from a prospective cohort study of 34,191 consecutive patients of whom 71.9% received office based deep sedation/general anesthesia, 15.5 % received conscious sedation, and 12.6 % received local anesthesia. Study methods included an audit of data collection to reduce selection bias and ensure cases were entered consecutively. Data was collected from 79 oral surgeons between January 2001 and December 2001 at 58 study sites between located in six geographical regions of the United States. Most complications were minor and self limiting and two patients required hospitalization. There were no deaths.

Lee<sup>48</sup> et al published a prospective comparison study of the safety of anesthetic outcomes of propofol and methohexital anesthesia administered to 47,710 consecutively assigned patients between January 2001 and December 2007. 0.7 % experienced adverse events, mostly post operative nausea and vomiting without aspiration, laryngospasm in the methohexital group, and syncope or prolonged emergence. Nine patients required hospitalization due allergic reaction to antibiotics and minor surgical complications such as persistent pain or wound problems (3 patients) to prolonged emergence with delirium and one case of bronchospasm with aspiration, one due to new onset dysrhythmia and two were not described. The study reported no deaths or brain damage. The study included 2404 patients who received anesthesia from a physician anesthesiologist or CRNA. This arm of the study was underpowered but reported no significant difference between providers.

---

<sup>47</sup> Perrott, D. H., Yuen, J. P., Andresen, R. V., & Dodson, T. B. (2003). Office-based ambulatory anesthesia: Outcomes of clinical practice of oral and maxillofacial surgeons. *Journal of Oral and Maxillofacial Surgery*, 61(9), 983–995. [http://doi.org/10.1016/S0278-2391\(03\)00668-2](http://doi.org/10.1016/S0278-2391(03)00668-2)

<sup>48</sup> Lee, J. S., Gonzalez, M. L., Chuang, S. K., & Perrott, D. H. (2008). Comparison of Methohexital and Propofol Use in Ambulatory Procedures in Oral and Maxillofacial Surgery. *Journal of Oral and Maxillofacial Surgery*, 66(10), 1996–2003. <http://doi.org/10.1016/j.joms.2008.06.028>.

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Inverso et al <sup>49</sup> compared the complications of moderate sedation with deep sedation/general anesthesia for 29,548 adolescent patients with average age of 17.3 undergoing third molar surgery between January 2001 and December 2010. Prospective data was collected from 79 surgeons at 58 sites across the US. As with previous studies the most common complications were post operative nausea and vomiting, prolonged recovery, syncope, and laryngospasm with a complication rate of 0.8% overall. There were no reports of new neurologic impairment and apparently no deaths. Patients receiving moderate sedation had a nominally lower rate of complications but this was not statistically significant.

Other investigators of anesthesia outcomes have utilized similar sized populations and have noted that very large populations must be studied to fully evaluate the occurrence of rare but serious outcomes such as brain injury or death. These studies may be underpowered to identify rare but serious outcomes such as death and brain damage. Large scale multi center studies are necessary, but the resources necessary to enroll populations of sufficient size and to maintain adequate controls are significant. High quality studies of pediatric dental sedation outcomes might be accomplished through a well established national outcomes registry.

---

<sup>49</sup> Inverso, G., Dodson, T. B., Gonzalez, M. L., & Chuang, S.-K. (2016). Complications of Moderate Sedation Versus Deep Sedation/General Anesthesia for Adolescent Patients Undergoing Third Molar Extraction. *Journal of Oral and Maxillofacial Surgery*, 74(3), 474–479. <http://doi.org/10.1016/j.joms.2015.10.009>



# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

**Figure 1 - Anesthesia outcomes – literature reviewed**

investigator	years	Data type	Anesthesia related mortality	Anesthesia solely responsible
Eichorn et al	1976-1988	1,001,000 anesthetics in ASA I and II - reports to malpractice carrier	1:200,200	---
Lagasse et al	1995-1999	peer review reports ASA I and II patients	1:126,711	0
Li et al	1999-2005	ICD codes, Center for Health Statistics, CDC	8.2/1,000,000 (95% CI 7.4-9.0)	---
Gonzales et al	2001-2011	systematic review of 20 trials pediatric studies all ASA	0.41-13.4/10,000	---
Schiff et al	1999-2010	Core data set – national standardized tracking data base 1,374,678 anesthetics ASA I and II elective cases Secondary German hospitals	26.2/1,000,000 (95% CI 19.4-34.6)	7.3/1000,000 (95%CI 3.9-12.3)

## Closed claims data

In a 1999 landmark study Cheney at al<sup>50</sup> describes how the study of insurance company closed claims provides a cost-effective approach to data collection with extensive data on injuries that occurred in many different institutions gathered in a centralized location. Typically, a closed claim file consists of the hospital record, the anesthesia record, and narrative statements of the involved healthcare personnel, expert and peer reviews, deposition summaries, outcome

---

<sup>50</sup> Cheney, F. W. (1999). The American Society of Anesthesiologists Closed Claims Project: what have we learned, how has it affected practice, and how will it affect practice in the future? *Anesthesiology*, 91(2), 552–556. Retrieved from <http://anesthesiology.pubs.asahq.org/article.aspx?articleid=1946221>

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

reports, and the cost of settlement or jury awards. These files provide a collection of information on the relatively rare events leading to anesthesia-related injury.

Although the use of closed claims circumvents the problem of gaining access to low-frequency adverse events, this approach has inherent limitations that must be considered when interpreting the data. For example, closed claims review does not provide information as to how many anesthetics were administered. Therefore, closed claims data does not provide a denominator for calculating the risk of anesthetic injury. In addition, some injured patients do not file claims, whereas others without any apparent injury do file claims. Closed claims analysis provides a snapshot of anesthesia liability, but is not a comprehensive picture of all anesthetic injury. Injuries leading to claims are not a random sample of all injuries, and we do not know how closely this snapshot resembles the whole picture of anesthetic injury. Another limitation of closed claims analysis is the retrospective nature of data collection. The information was gathered by the insurance companies for the purpose of resolving the claims, not for patient safety research. Data from different sources may be conflicting, and some data may be missing. In addition, it takes an average of 5 years for cases to become available for review due to the time necessary for them to be resolved. Closed claims analysis is useful for generating hypotheses about the mechanism and prevention of anesthetic injury, but cannot be used for testing of those hypotheses. As a retrospective study, it cannot establish a cause-and effect relationship of previous events, nor of changes in claim experience.

Closed claims data also provides information about risk related to the location in which sedation and anesthesia is administered. Domino's<sup>51</sup> original report indicated that the severity of injury was greater for office based claims than for other ambulatory settings, with 40% for death compared to 25% for other ambulatory claims. Respiratory events, airway obstruction, bronchospasm, inadequate oxygenation-ventilation and esophageal intubation were the most common complications (29%). These adverse events were deemed preventable through better monitoring.

Monitored anesthesia care (MAC) accounted for 50% of out of operating room claims. Respiratory depression from MAC accounted for 21% of claims and death or permanent brain damage accounted for 40% of MAC claims. Although this proportion is similar to general anesthesia claims and suggests that MAC and general anesthesia have similar risk profiles,

---

<sup>51</sup> Domino, K. B. (n.d.). Office-Based Anesthesia : Lessons Learned from the Closed Claims Project, 9–12. ASA Newsletter 65 (6) 2001.

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Bhananker's study<sup>52</sup> includes outcomes from MAC in both inpatient and outpatient facilities making it difficult to draw conclusions about the safety of MAC in outpatient facilities. Jiminez<sup>53</sup> et al reported a study of closed pediatric claims between the 1970's and the 1990's. Death and brain damage were the most common reason for claims in the 16 or younger age group. 77% of cases involved relatively healthy patients with ASA PS 1 or 2, and the most common procedures involved the airway. The proportion of claims assessed as preventable by better monitoring decreased from an average of 63% in the 1970's to 16% in the 1990's, possibly due to better monitoring, however cardiovascular events (26%) joined respiratory events as being most important. The authors indicate that the policy implications of the data are unclear; including whether pediatric anesthesia specialists provide safer care for younger higher risk patients and what type of case should be performed in what type of facility.

Closed claims review has also been utilized as a data source to study dental sedation/anesthesia related morbidity and mortality. Jastak and Peskin<sup>54</sup> evaluated 13 claims that occurred between 1974 and 1989 from patients of all ages. Adverse outcomes were most often due to airway obstruction or respiratory depression resulting in hypoxia and 10 of 13 cases were judged to be avoidable through the use of better monitoring. The majority of patients had pre existing medical conditions and were rated as ASA II or III. The authors conclude that the very old and very young are at greatest risk.

Deegan<sup>55</sup> reported 136 claims from the American Association of Oral and Maxillofacial Surgeons National Insurance Company accumulated between 1988 and 1999. At that time AAOMS National insured approximately 55% of the oral surgeons practicing in the US. Thirty

---

<sup>52</sup> Sanjay M. Bhananker, M.D., F.R.C.A.,\* Karen L. Posner, Ph.D.,† Frederick W. Cheney, M.D.,‡ Robert A. Caplan, M. D., & Lorri A. Lee, M.D., Karen B. Domino, M.D., M. P. H. (2006). Injury and Liability Associated with Monitored Anesthesia. *Anesthesiology*, *104*(2), 228–234.

<sup>53</sup> Jimenez, N., Posner, K. L., Cheney, F. W., Caplan, R. A., Lee, L. A., & Domino, K. B. (2007). An update on pediatric anesthesia liability: A closed claims analysis. *Anesthesia and Analgesia*, *104*(1), 147–153. <http://doi.org/10.1213/01.ane.0000246813.04771.03>

<sup>54</sup> Jastak, J. T., & Peskin, R. M. (1991). Major morbidity or mortality from office anesthetic procedures: a closed-claim analysis of 13 cases. *Anesthesia Progress*, *38*(2), 39–44.

<sup>55</sup> Deegan, a E. (2001). Anesthesia morbidity and mortality, 1988-1999: claims statistics from AAOMS National Insurance Company. *Anesthesia Progress*, *48*(3), 89–92. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2007373&tool=pmcentrez&rendertype=abstract>

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

seven claims involved serious injury or hypoxic brain damage as the result of both office and inpatient anesthesia. The authors state that there were equal numbers of claims from both conscious sedation and general anesthesia. Unlike most other closed claims studies the authors provide an estimate of the total number of cases performed and an estimate of the incidence of office deaths as 1: 747,000 administrations. There were 23 deaths and one brain damage case from office anesthesia and 11 deaths and 4 brain damage cases from inpatient anesthesia provided by anesthesiologists or nurse anesthetists.

Nkansah<sup>56</sup> et al published a report of anesthesia outcomes for oral and maxillofacial surgeons from the Canadian province of Ontario utilizing claims data from the Regional professional liability program that covers all claims originating from Ontario between 1973 and 1995. The Canadian model of anesthesia delivery is similar to that utilized in the US, with the OMS administering the anesthesia and performing the surgery with trained assistants. The authors provide an estimate of total cases performed during the study interval via survey of members of the professional association. Four deaths occurred, with one administered by a dentist anesthesiologist and three by oral and maxillofacial surgeons. A single case involving anesthesia administered by a physician anesthesiologist was excluded. The author estimates an incidence of mortality of 1.4 per 1,000,000.

A more recent closed claims review by Chicka<sup>57</sup> et al evaluated adverse events during pediatric dental sedation. This study reviewed 17 claims accumulated between 1993 and 2007 from two major insurance carriers. Reports were limited to pediatric cases age <13 with 78% age 5 or less. 13 claims involved sedation, 3 involved local anesthesia alone, and one involved general anesthesia. The average age of the patient was 3.6 years and only one case involved the use of physiologic monitoring. The study included only claims from office based treatment. Over half (53%) were claims from a death or permanent brain damage.

Bennett et al published the most recent closed claims study of dental cases, reporting information from 113 closed claims cases from the files of a national insurance carrier for

---

<sup>56</sup> Nkansah, P. J., Haas, D. A., & Saso, M. A. (1997). Mortality incidence in outpatient anesthesia for dentistry in Ontario. *Oral Surgery, Oral Medicine, Oral Pathology*, 83(6), 646–651.

<sup>57</sup> Chicka, M. C., Dembo, J. B., Mathu-Muju, K. R., Nash, D. A., & Bush, H. M. (2012). Adverse events during pediatric dental anesthesia and sedation: a review of closed malpractice insurance claims. *Pediatr Dent*, 34(3), 231–238.

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

approximately 80% of oral and maxillofacial surgeons practicing in the United States.<sup>58</sup> This company tracks the number of anesthetics performed annually. Claims were for cases that resulted in death or brain injury collected over 14 years, between 2000-2013. The authors do not provide details that indicate specific adverse events or contributing factors, but indicate that the majority of adverse outcomes are related to respiratory events. This study did not provide patient age related data. Unlike most other closed claims studies this report provides an estimate of the overall number of cases performed and an estimate of the incidence of anesthesia morbidity and mortality as one per 348,602 cases.

## State Board Data

Investigators have attempted to gather information from state dental boards; however collection and storage of data vary state to state which limits the value of this data. State board outcomes data has the potential to inform policy decisions. State laws specify mandatory reporting of patient deaths or hospitalization. This improves the reliability of dental board data compared to closed claims reports or self reporting by the members of professional associations. The total number of patients treated, however, remains unknown. This makes accurate calculation of the incidence and prevalence of adverse events impossible because, as with closed claims data, there is no “denominator”. Death and serious injury cases often involve lengthy legal proceedings that require 3 or more years to elapse before information can be made available. Dental boards collect information to manage enforcement actions, not for clinical research, and state records retention and disclosure policies may conflict with data collection. Standardization of data collection across state dental boards has the potential to provide meaningful information, however this has yet to occur.

Krippaehne and Montgomery requested morbidity and mortality information from dental boards in all 50 states and Puerto Rico related to either general anesthesia or sedation in dental offices. The information requested included the formal complaint, the formal order and judgment by the board, expert opinions, and the medical examiner’s report. They received responses from all states and Puerto Rico; however, most states had not kept records on such

---

<sup>58</sup> Bennett, J. D., Kramer, K. J., & Bosack, R. C. (2015). How safe is deep sedation or general anesthesia while providing dental care? *J Am Dent Assoc*, 146(9), 705–708.  
<http://doi.org/10.1016/j.adaj.2015.04.005>

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

cases and hence, could not contribute to the data base. Forty-three cases were reported by nine states, with mortality comprising 81% of the cases.<sup>59</sup>

Dental board data provides important details of adverse outcomes from sedation and anesthesia that may not be available from other sources. As with closed claims data, dental board data is retrospective, but is still useful in generating a hypothesis about the mechanism of injury and how it might be prevented in the future.

## Dental Sedation and Anesthesia Outcomes Reports

### The Pediatric Sedation Research Consortium

The Pediatric Sedation Research Consortium (PSRC) has made significant contributions to pediatric sedation research, demonstrating a remarkable safety record for sedation provided by highly motivated and skilled practitioners from a variety of specialties functioning outside the operating room. The PSRC collected data from 37 participating institutions within large children's hospitals, children's hospitals within hospitals and general/community hospitals.<sup>60</sup> The Consortium has published a series of prospective observational studies that have demonstrated many of the concepts important to the safe administration of pediatric sedation. Over time the PSRC has accumulated a large database of children up to age 21.

The authors of the PSRC studies describe the limitations of their studies. Reporting institutions are self selected for voluntarily reporting of their outcomes, and represent a highly motivated and organized systems that would outperform other, less controlled systems and may represent "best practice." The practice patterns and outcomes of the PSRC represent a highly competent cohort that may not generalize to other clinical settings in which sedation care is provided.<sup>61</sup>

---

<sup>59</sup> Krippaehne, J. A., & Montgomery, M. T. (1992). Morbidity and mortality from pharmacosedation and general anesthesia in the dental office. *Journal of Oral and Maxillofacial Surgery*. [http://doi.org/10.1016/0278-2391\(92\)90099-L](http://doi.org/10.1016/0278-2391(92)90099-L)

<sup>60</sup> Cravero, J. P., Blike, G. T., Beach, M., Gallagher, S. M., Hertzog, J. H., Havidich, J. E., & Gelman, B. (2006). Incidence and nature of adverse events during pediatric sedation/anesthesia for procedures outside the operating room: report from the Pediatric Sedation Research Consortium. *Pediatrics*, *118*(3), 1087–1096. <http://doi.org/10.1542/peds.2006-0313>

<sup>61</sup> Cravero, J. P., Blike, G. T., Beach, M., Gallagher, S. M., Hertzog, J. H., Havidich, J. E., & Gelman, B. (2006). Incidence and nature of adverse events during pediatric sedation/anesthesia

## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

Although the PSRC studies include data from a wide variety of providers dentists are significantly underrepresented in this series. Only 0.80% or 397 of nearly 50,000 cases were dental cases. Dentists are grouped in the “other” category with pediatric residents or fellows, radiologists, surgeons, advanced practice nurses, certified registered nurse anesthetists, and registered nurses. In addition the PSRC data was accumulated from inpatient facilities such as pediatric hospitals and community hospitals with pediatric sedation services that are not usually utilized for dentistry. As a result it is impossible to generalize results from the PSRC studies to community dental practices. Nevertheless the “best practices” utilized at PSRC facilities have broad application to pediatric sedation in all settings.

Coulores et al reported the results of an analysis of 133,941 procedural sedation records from the PSRC that evaluated a comparison of the major complication frequency of sedation performed by pediatric specialists outside of the operating room. There was no statistical difference between different sedation providers’ major complication rates.<sup>62</sup>

Langhan et al reported the results a study of physiologic monitoring practices during pediatric sedation from the PSRC.<sup>63</sup> Data from 114 855 subjects were collected and analyzed. The frequency of use of each physiologic monitoring modality by health care provider type, medication used, and procedure performed varied significantly. The largest difference in frequency of monitoring use was seen between providers using electrocardiography (13%-95%); the smallest overall differences were seen in monitoring use based on the American Society of Anesthesiologists classifications (1%-10%). Guidelines published by the American Academy of Pediatrics, the American College of Emergency Physicians, and the American Society of Anesthesiologists for non anesthesiologists were adhered to for only 52% of subjects.

Despite the variability in monitoring, serious adverse outcomes during procedural sedation were uncommon. The authors conclude that further research is needed to develop evidence-

---

for procedures outside the operating room: report from the Pediatric Sedation Research Consortium. *Pediatrics*, 118(3), 1087–1096. <http://doi.org/10.1542/peds.2006-0313>

<sup>62</sup> Coulores, K. G., Beach, M., Cravero, J. P., Monroe, K. K., & Hertzog, J. H. (2011). Impact of provider specialty on pediatric procedural sedation complication rates. *Pediatrics*, 127(5), e1154–60. <http://doi.org/10.1542/peds.2010-2960>

<sup>63</sup> Langhan, M. L., Mallory, M., Hertzog, J., Lowrie, L., & Cravero, J. (2012). Physiologic monitoring practices during pediatric procedural sedation: a report from the Pediatric Sedation Research Consortium. *Arch Pediatr Adolesc Med*, 166(11), 990–998. <http://doi.org/10.1001/archpediatrics.2012.1023>

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

based guidelines regarding the appropriateness of various monitoring modalities and their effect on adverse outcomes that are associated with sedation.

Cravero, et al reported the results of a study of data from thirty seven locations that submitted data on 49,836 propofol sedation.<sup>64</sup> The authors state that given the potency of propofol and the nature of pediatric patients, essentially all children administered propofol would clearly be categorized as being deeply sedated or anesthetized. Despite varying guidelines, propofol sedation/anesthesia is delivered to children for procedures in emergency departments, intensive care units, and sedation/anesthesia units all over the United States (and around the world) by pediatric generalists and subspecialists every day.

The authors stress that the results of their study should not reassure providers that propofol sedation/anesthesia of children is safe, but it helps define the competencies required to deliver this care.

## Summary

Review articles identify very few high quality published reports and clinical trials related to pediatric sedation for dentistry. This may be due to the practical difficulties of enrolling sufficient number of children into adequately controlled and blinded studies.

Because significant anesthesia injury is a relatively rare occurrence, it is difficult to study prospectively or by retrospective medical record review, even when data is collected from multiple institutions.

The effect that provider type or personnel type has on outcomes has received little study, particularly as related to pediatric dentistry.

There is no standardized definition of anesthesia related mortality, and this determination often relies on subjective interpretation. Differences in methodology make it difficult to compare mortality rates among different studies because the mortality rate may depend on the surgical population being studied. Available studies do not support a firm conclusion, but

---

<sup>64</sup> Cravero, J. P., Beach, M. L., Blike, G. T., Gallagher, S. M., & Hertzog, J. H. (2009). The incidence and nature of adverse events during pediatric sedation/anesthesia with propofol for procedures outside the operating room: a report from the pediatric sedation research consortium. *Anesthesia and Analgesia*, 108(3), 795–804.  
<http://doi.org/10.1213/ane.0b013e31818fc334>



## DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

suggest that anesthesia related mortality for ASA I and II patients treated in inpatient facilities is in the range of 1:250,000.

Several studies indicate that the most common complications of pediatric sedation include respiratory events such as desaturation, apnea and laryngospasm with cardiac arrest occurring as a second or third event. Complications may be more frequent under age 6, with younger patients and higher ASA physical status classification III or IV at greater risk. Causes or contributing factors include drug related events, inadequate monitoring, inadequate resuscitation, and inadequate medical evaluation.

Although pediatric sedation has an excellent safety record, adverse outcomes sometimes occur in apparently healthy patients indicating that there is inherent risk in sedation and general anesthesia.

DRAFT

# DBC ANESTHESIA WORKING DOCUMENT- JULY, 2016

**Figure 2 - Dental Sedation Literature Reviewed**

Investigator	years	data type	anesthesia related mortality	anesthesia solely responsible
Cote et al (2000)	1969-1996	FDA adverse drug reaction reports; USP reports; physician surveys	51	51
Nkansah et al (1997, Canada)	1973-1995	Closed claims + provincial authority reports	4	4
Jastak et al	1974-1989	Closed claims review – all dentists' pts. All ages	13	10
Deegan et al	1988-1989	Closed claims review - oral surgery only	44	44
Perrott et al (2003)	2001	Prospective cohort study of 34,191 oral surgery cases	none	----
Chicka et al	1993-2007	Closed claims of pediatric dental cases age <13	17	17 including local anes.
Lee, J. et al (2008)	2001-2007	Prospective cohort study of propofol vs. methohexital 47, 710 oral surg cases	none	---
Lee, H. et al (2013)	1980-2011	media reports of pediatric dental < age 21	44	44
Bennett et al (2015)	2000-2013	Closed claims review oral surgery only	113	113
Inverso et al (2015)	2001-2010	Prospective study of 29,548 adolescent oral surg patients average age 17.3	none	---



## **Dental advanced educational programs that include training in moderate sedation, deep sedation, and general anesthesia**

### **CODA accreditation of advanced educational programs**

The Commission on Dental Accreditation (CODA) was established in 1975 and is nationally recognized by the United States Department of Education (USDE) as the sole agency to accredit dental and dental-related education programs conducted at the post-secondary level. CODA accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public recognition for compliance with accepted standards of quality and performance. Accreditation standards are developed in consultation with those affected who represent broad communities of interest. A comparison table of education for training in various levels of sedation is included as Appendix 2 Table 1.

### **Postgraduate CODA approved residencies that require deep sedation-general anesthesia training.**

#### **Oral and Maxillofacial Surgery (OMS) (48-72 months of Post Graduate Education)<sup>1</sup>**

OMS's complete, at a minimum, a post graduate CODA approved residency of 48 months (single degree-DDS). Approximately half of those trained complete a 72 month residency (dual degree-DDS,MD).

The following CODA approved post graduate residency training programs (after dental school-4 years) require 36 months for dental anesthesiology, 30 months for periodontics, 24 months for pediatric dentistry, and 12-24 months for general practice (GPR).

#### *OMS Sedation / General Anesthesia Training During Residency Training*

- During OMS training, a resident completes the equivalency of a PGY1 year of anesthesia training.
- During the four or six year residency, each resident receives didactic education in subjects related to anesthesia including anatomy, pharmacology, and physiology, patient evaluation, risk assessment, anesthesia and sedation techniques, patient monitoring, and diagnosis and management of emergency complications. They also complete a structured course in physical diagnosis including patient evaluation and risk assessment.

---

<sup>1</sup> CODA. (2012). Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery. Retrieved from <https://www.ada.org/~media/CODA/Files/oms.pdf?la=en>

- The clinical training currently includes five (5) months on the hospital medical anesthesia service functioning at an anesthesia resident (PGY1) level with responsibility for patient evaluation, risk assessment, anesthesia and sedation techniques, patient monitoring, and diagnosis and management of complications.
- Clinical experience shall also include training to competency in airway management (simple, direct/ fiber optic intubation, emergency tracheotomy).
- CODA training requirements require the resident to perform 300 cases of general anesthesia of which 50 are pediatric patients and 150 of the 300 must be ambulatory anesthesia for OMS.
- CODA approved training also requires hospital based rotations with the resident functioning at a PGY1 level: two (2) months on the medicine service (for non MD programs); four (4) months on the general or a sub-specialty surgery service; and a rotation on the hospital emergency service.
- In addition, the OMS resident is required to complete the following certifications: Advanced Trauma Life Support (ATLS); Certification and currency in Advanced Cardiac Life Support (ACLS); and Pediatric Advanced Life Support (PALS).

### **Dental Anesthesiology<sup>2</sup>** (36 month Post Graduate Education)

Note: until recently, a CODA approved residency in dental anesthesiology was 24 months. The current residents in dental anesthesiology must receive didactic instruction at an advanced in-depth level for applied biomedical sciences foundational to dental anesthesiology, physical diagnosis and evaluation, methods of anxiety and pain control, complications and emergencies, and pain management.

The clinical requirements must include a minimum of 24 months in anesthesia with a minimum of this period of 6 months devoted to dental anesthesiology. Twelve months over the 36 month period must be assigned full-time to a hospital anesthesia service. They must complete 800 total cases of deep sedation/general anesthesia: 300 cases must be intubated general anesthetics including 50 nasal intubations and 25 advanced airway management techniques; 125 children age 0-7seven; and 75 patients with special needs. At least 100 of 800 cases must be out-patient anesthesia for dentistry and the resident must be the provider. Additionally, the resident must participate in four (4) months of clinical medical rotations of internal medicine; intensive care; pain medicine; pediatrics; or pulmonary medicine.

---

<sup>2</sup> CODA. (2012). Accreditation Standards For Advanced General Dentistry Education Programs in Dental Anesthesiology. Retrieved from <https://www.ada.org/~media/CODA/Files/anes.pdf?la=en>

## **Postgraduate CODA approved residencies that include moderate sedation training.**

### **Periodontics (30 month Post Graduate Education)**

The periodontics training standards state the program must provide training in the methods of pain control and sedation. They must achieve knowledge in all areas of minimal, moderate, and deep sedation and be trained to a level of competency in adult minimal enteral and moderate parenteral sedation.

### **Pediatric Dentistry<sup>3</sup> (24 month Post Graduate Education)**

The pediatric dentistry training standards require education in anatomy, pharmacology, and principles and objectives of sedation and general anesthesia as behavioral guidance techniques including indications and contraindications for their use in accordance with the ADA Standards for Teaching of Pain Control and Sedation to Dentists and Dental Students. Clinical experience must include infants, children, adolescents, and patients with special needs for inhalation analgesia (nitrous oxide/oxygen) and sedation. Therefore they must perform 20 inhalation analgesia cases as primary operator, 50 patient encounters in which sedative agents (other than nitrous oxide/oxygen) by any route are used and must act as the operator in a minimum of 25 sedation cases.

### **General Practice Residency (12-24 months Post Graduate Training)**

The general practice residency standards require the resident to receive education and training beyond pre-doctoral training including pain and anxiety control utilizing behavioral and/or pharmacological techniques. For clinical experience, residents must be assigned to an anesthesia rotation for a minimum 70 hours to gain experience in preoperative evaluation, assessment of the effects of behavioral and pharmacologic techniques, venipuncture technique, patient monitoring, airway management, understanding of the use of pharmacologic agents, recognition and treatment of anesthetic emergencies, and assessment of patient recovery from anesthesia. Additional clinical experience includes interpreting clinical and other diagnostic data from other health care providers, using the services of clinical medicine and pathology, and performing a history and physical evaluation and collecting other data necessary to establish a medical assessment.

---

<sup>3</sup> CODA. (2015). Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry. Retrieved from <https://www.ada.org/~media/CODA/Files/ped.pdf?la=en>

## **American Society of Anesthesiologists Training recommended for non-anesthesiologists seeking privileges to administer deep sedation<sup>4</sup>**

### **EDUCATION AND TRAINING**

The non-anesthesiologist sedation practitioner will have satisfactorily completed a formal training program in (1) the safe administration of sedative and analgesic drugs used to establish a level of deep sedation, and (2) rescue of patients who exhibit adverse physiologic consequences of a deeper-than-intended level of sedation. This training may be a formally recognized part of a recently completed Accreditation Council for Graduate Medical Education (ACGME) residency or fellowship training (e.g., within two years), or may be a separate deep sedation educational program that is accredited by Accreditation Council for Continuing Medical Education (ACCME) or equivalent providers recognized for dental, oral surgical and podiatric continuing education, and that includes the didactic and performance concepts below. A knowledge-based test is necessary to objectively demonstrate the knowledge of concepts required to obtain privileges. The following subject areas will be included:

- 3.1** Contents of the following ASA documents (or their more current version if subsequently modified) that will be understood by practitioners who administer sedative and analgesic drugs to establish a level of deep sedation.
  - 3.1.1 Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology* 2002; 96; 1004-1017.
  - 3.1.2 Continuum of Depth of Sedation; Definition of General Anesthesia and Levels of Sedation/Analgesia (ASA HOD 2004, amended 2009)
  - 3.1.3 Standards for Basic Anesthetic Monitoring (Approved by the ASA House of Delegates on October 21, 1986, and last amended on October 25, 2005)
  - 3.1.4 Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures (Approved by ASA House of Delegates on October 21, 1998, and effective January 1, 1999)
- 3.2** Appropriate methods for obtaining informed consent through pre-procedure counseling of patients regarding risks, benefits and alternatives to the administration of sedative and analgesic drugs to establish a level of deep sedation.

---

<sup>4</sup> American Society of Anesthesiologists. (2010). Advisory on granting privileges for deep sedation to non-anesthesiologist sedation practitioners. Retrieved from <http://www.asahq.org/~media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/advisory-on-granting-privileges-for-deep-sedation-to-non-anesthesiologist.pdf>

- 3.3** Skills for obtaining the patient’s medical history and performing a physical examination to assess risks and co-morbidities, including assessment of the airway for anatomic and mobility characteristics suggestive of potentially difficult airway management. The non-anesthesiologist sedation practitioner will be able to recognize those patients whose medical condition requires that sedation needs to be provided by an anesthesia professional, such as morbidly obese patients, elderly patients, pregnant patients, patients with severe systemic disease, patients with obstructive sleep apnea, or patients with delayed gastric emptying.
  
- 3.4** Assessment of the patient’s risk for aspiration of gastric contents as described in the ASA Practice Guidelines for Preoperative Fasting. In urgent, emergent or other situations where gastric emptying is impaired, the potential for pulmonary aspiration of gastric contents must be considered in determining
  - 3.4.1 The target level of sedation
  - 3.4.2 Whether the procedure should be delayed
  - 3.4.3 Whether the sedation care should be transferred to an anesthesia professional for the delivery of general anesthesia with endotracheal intubation.
  
- 3.5** The pharmacology of
  - 3.5.1 All sedative and analgesic drugs the practitioner requests privileges to administer to establish a level of deep sedation
  - 3.5.2 Pharmacological antagonists to the sedative and analgesic drugs
  - 3.5.3 Vasoactive drugs and antiarrhythmics.
  
- 3.6** The benefits and risks of supplemental oxygen.
  
- 3.7** Recognition of adequacy of ventilatory function: This will include experience with patients whose ventilatory drive is depressed by sedative and analgesic drugs as well as patients whose airways become obstructed during sedation. This will also include the ability to perform capnography and understand the results of such monitoring. Non-anesthesiologist practitioners will demonstrate competency in managing patients during deep sedation, and understanding of the clinical manifestations of general anesthesia so that they can ascertain when a patient has entered a state of general anesthesia and rescue the patient appropriately.
  
- 3.8** Proficiency in advanced airway management for rescue: This training will include appropriately supervised experience to demonstrate competency in managing the airways of patients during deep sedation, and airway management using airway models as well as using high-fidelity patient simulators. The non-anesthesiologist practitioner must demonstrate the ability to reliably perform the following:
  - 3.8.1. Bag-valve-mask ventilation
  - 3.8.2 Insertion and use of oro- and nasopharyngeal airways



3.8.3 Insertion and ventilation through a laryngeal mask airway

3.8.4 Direct laryngoscopy and endotracheal intubation

This will include clinical experience on no less than 35 patients or equivalent simulator experience (See ACGME reference). The facility with oversight by the Director of Anesthesia Services will determine the number of cases needed to demonstrate these competencies, and may increase beyond the minimum recommended.

**3.9** Monitoring of physiologic variables, including the following:

3.9.1 Blood pressure.

3.9.2 Respiratory rate.

3.9.3 Oxygen saturation by pulse oximetry with audible variable pitch pulse tone.

3.9.4 Capnographic monitoring. The non-anesthesiologist practitioner shall be familiar with the use and interpretation of capnographic waveforms to determine the adequacy of ventilation during deep sedation.

3.9.5 Electrocardiographic monitoring. Education in electrocardiographic (EKG) monitoring will include instruction in the most common dysrhythmias seen during sedation and anesthesia, their causes and their potential clinical implications (e.g., hypercapnia), as well as electrocardiographic signs of cardiac ischemia.

- 3.9.6 Depth of sedation. The depth of sedation will be based on the ASA definitions of “deep sedation” and “general anesthesia.” (See below).
- 3.10** The importance of continuous use of appropriately set audible alarms on physiologic monitoring equipment.
- 3.11** Documenting the drugs administered, the patient’s physiologic condition and the depth of sedation at five-minute intervals throughout the period of sedation and analgesia, using a graphical, tabular or automated record which documents all the monitored parameters including capnographic monitoring. The importance of monitoring the patient through the recovery period and the inclusion of specific discharge criteria for the patient receiving sedation.
- 3.12** Regardless of the availability of a “code team” or the equivalent, the non-anesthesiologist practitioner will have advanced life support skills and current certificate such as those required for Advanced Cardiac Life Support (ACLS). When granting privileges to administer deep sedation to pediatric patients, the non-anesthesiologist practitioner will have advanced life support skills and current certificate such as those required for Pediatric Advanced Life Support (PALS). Initial ACLS and PALS training and subsequent retraining shall be obtained from the American Heart Association or another vendor that includes “hands-on” training and skills demonstration of airway management and automated external defibrillator (AED) use.
- 3.13** Required participation in a quality assurance system to track adverse outcomes and unusual events including respiratory arrests, use of reversal agents, prolonged sedation in recovery process, larger than expected medication doses, and occurrence of general anesthesia, with oversight by the Director of Anesthesia services or their designee.
- 3.14** Knowledge of the current CMS Conditions of Participation regulations and their interpretive guidelines pertaining to deep sedation, including requirements for the pre-anesthesia evaluation, anesthesia intra-operative record, and post-anesthesia evaluation.

Separate privileging is required for the care of pediatric patients. When the non-anesthesiologist practitioner is granted privileges to administer sedative and analgesic drugs to pediatric patients to establish a level of deep sedation, the education and training requirements enumerated in #1-15 above will be specifically defined to qualify the practitioner to administer sedative and analgesic drugs to pediatric patients.

#### **4. LICENSURE**

- 4.1** The non-anesthesiologist sedation practitioner will have a current active, unrestricted medical, osteopathic, or dental license in the state, district or territory of practice. (Exception: practitioners employed by the federal government may have a current active license in any U.S. state, district or territory.)
- 4.2** The non-anesthesiologist sedation practitioner will have a current unrestricted Drug Enforcement Administration (DEA) registration (schedules II-V).

- 4.3 The privileging process will require disclosure of any disciplinary action (final judgments) against any medical, osteopathic or dental license by any state, district or territory of practice and of any sanctions by any federal agency, including Medicare/Medicaid, in the last five years.
- 4.4 Before granting or renewing privileges to administer or supervise the administration of sedative and analgesic drugs to establish a level of deep sedation, the health care organization shall search for any disciplinary action recorded in the National Practitioner Data Bank (NPDB) and take appropriate action regarding any Adverse Action Reports.

## **5. PERFORMANCE EVALUATION**

- 5.1 Before granting initial privileges to administer or supervise administration of sedative and analgesic drugs to establish a level of deep sedation, a process will be developed to evaluate the practitioner's performance and competency. For recent graduates (e.g., within two years), this may be accomplished through letters of recommendation from directors of residency or fellowship training programs that include deep sedation as part of the curriculum. For those who have been in practice since completion of their training, performance evaluation may be accomplished through specific documentation of performance evaluation data transmitted from department heads or supervisors at the institution where the individual previously held privileges to administer deep sedation. Alternatively, the non-anesthesiologist sedation practitioner could be proctored or supervised by a physician or dentist who is currently privileged to administer sedative and analgesic agents to provide deep sedation. The Director of Anesthesia Services with oversight by the facility governing body will determine the number of cases that need to be performed in order to determine independent competency in deep sedation.
- 5.2 Before granting ongoing privileges to administer or supervise administration of sedative and analgesic drugs to establish a level of deep sedation, a process will be developed to re-evaluate the practitioner's performance at regular intervals. Re-evaluation of competency in airway management will be part of this performance evaluation. For example, the practitioner's performance could be reviewed by an anesthesiologist or a non-anesthesiologist sedation practitioner who is currently privileged to administer deep sedation. The facility will establish an appropriate number of procedures that will be reviewed.

## **6. PERFORMANCE IMPROVEMENT**

Privileging in the administration of sedative and analgesic drugs to establish a level of deep sedation will require active participation in an ongoing process that evaluates the practitioner's clinical performance and patient care outcomes through a formal facility program of continuous performance improvement. The facility's deep sedation performance improvement program will be developed with advice from and with outcome review by the Director of Anesthesia Services.

- 6.1 The organization in which the practitioner practices will conduct peer review of its clinicians.

- 6.2** The performance improvement program will assess up-to-date knowledge as well as ongoing competence in the skills outlined in the educational and training requirements described above.
- 6.3** Continuing medical education in the delivery of anesthesia services is required for renewal of privileges.
- 6.4** The performance improvement program will monitor and evaluate patient outcomes and adverse or unusual events.
- 6.5** Any of the following events will be referred to the facility quality assurance committee for evaluation and performance evaluation:
  - 6.5.1 Unplanned admission
  - 6.5.2 Cardiac arrest
  - 6.5.3 Use of reversal agents
  - 6.5.4 Use of assistance with ventilation requiring bag-valve-mask ventilation or laryngeal or endotracheal airways.
  - 6.5.5 Prolonged periods of oxygen desaturation (<85% for 3 minutes)
  - 6.5.6 Failure of the patient to return to 20% of pre-procedure vital signs

## **7. DEFINITIONS**

**Anesthesia Professional:** An anesthesiologist, anesthesiologist assistant (AA), or certified registered nurse anesthetist (CRNA).

**Non-anesthesiologist Sedation Practitioner:** A licensed physician (allopathic or osteopathic); or dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; who has not completed postgraduate training in anesthesiology but is specifically trained to administer personally or to supervise the administration of deep sedation.



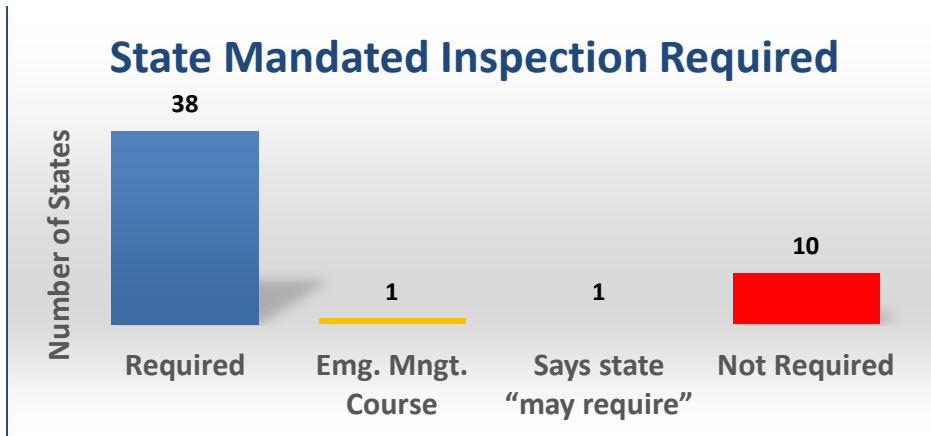
# Appendix 1

## Dental Anesthesia and Sedation in the 50 States

### Contents

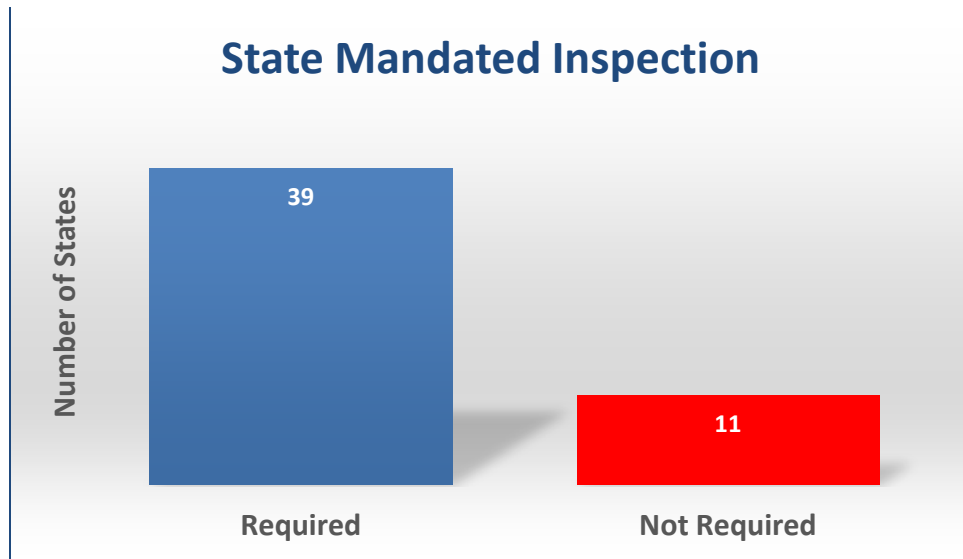
State mandated inspection for offices providing general anesthesia .....	1
Moderate Sedation State Mandated Office Inspection.....	2
Incremental monitoring requirements .....	2
Capnography.....	3
Detailed equipment list.....	3
Dental Assistants.....	4
Number of staff required.....	5
Continuing education.....	7
Pediatric sedation requirements .....	7

### State mandated inspection for offices providing general anesthesia



California requires an office inspection every 5 years for general anesthesia permit holders

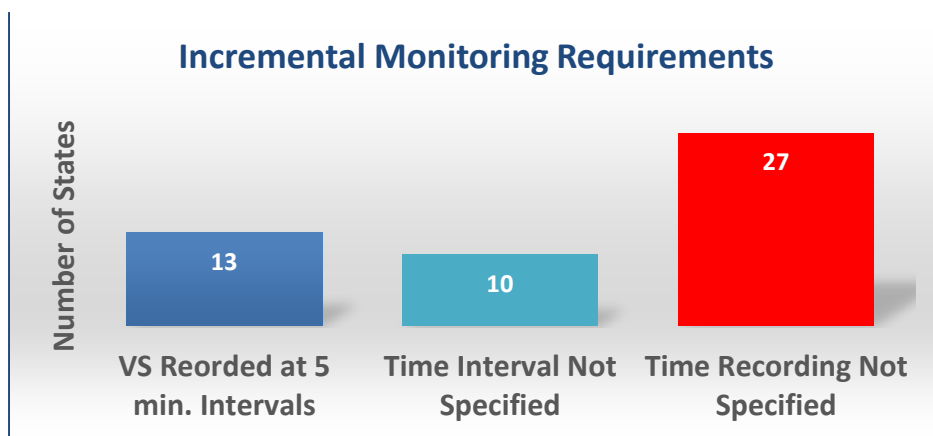
## Moderate Sedation State Mandated Office Inspection



**Conscious (moderate) IV sedation providers in California must undergo an office inspection every 6 years**

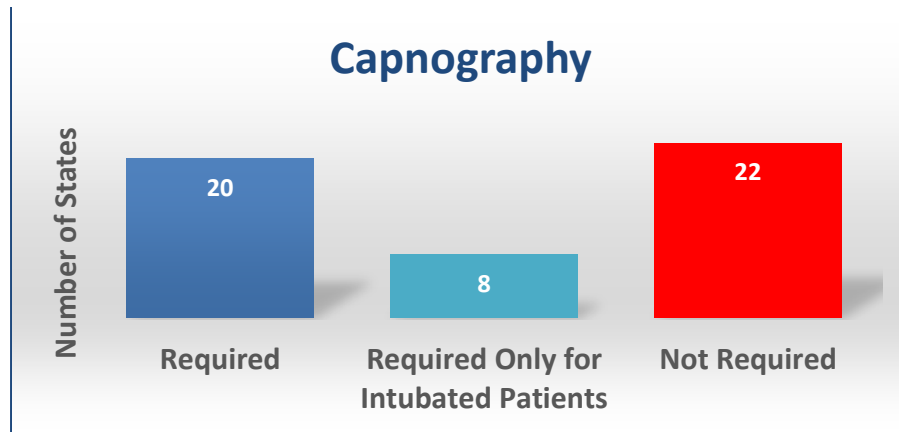
## Incremental monitoring requirements

### General Anesthesia



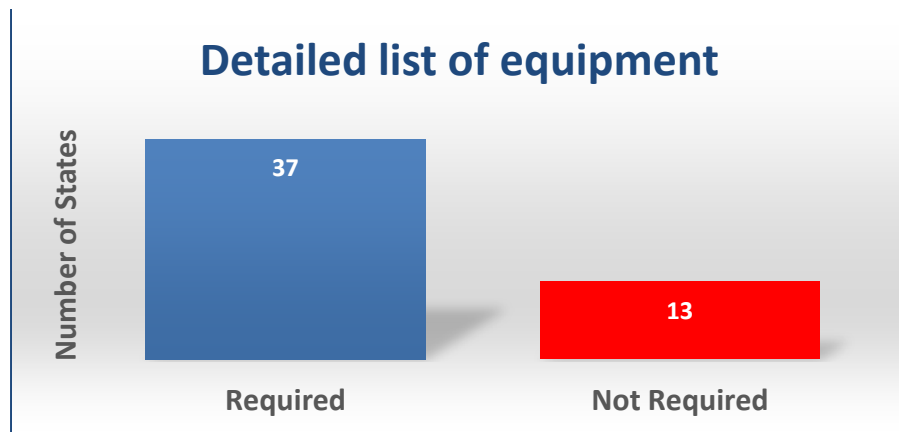
**California requires incremental recording of vital signs at 5 minute intervals intraoperatively and 15 minute intervals postoperatively**

## Capnography



**California law requires capnography for patients undergoing an intubated general anesthetic**

## Detailed equipment list



**California law requires a detailed list of ancillary equipment for both general anesthesia and moderate sedation, as well as specified patient monitors**

**A detailed list of equipment usually includes the following items:**

1. Laryngoscope complete with adequate selection of blades and spare batteries and bulb.
2. Endotracheal tubes and appropriate connectors
3. Emergency airway equipment (oral airways, laryngeal mask airways or combitubes, cricothyrotomy device)
4. Endotracheal tube forcep .
5. Sphygmomanometer and stethoscope.
6. Electrocardioscope and defibrillator.
7. Adequate equipment for the establishment of an intravenous infusion
8. Precordial/pretracheal stethoscope.

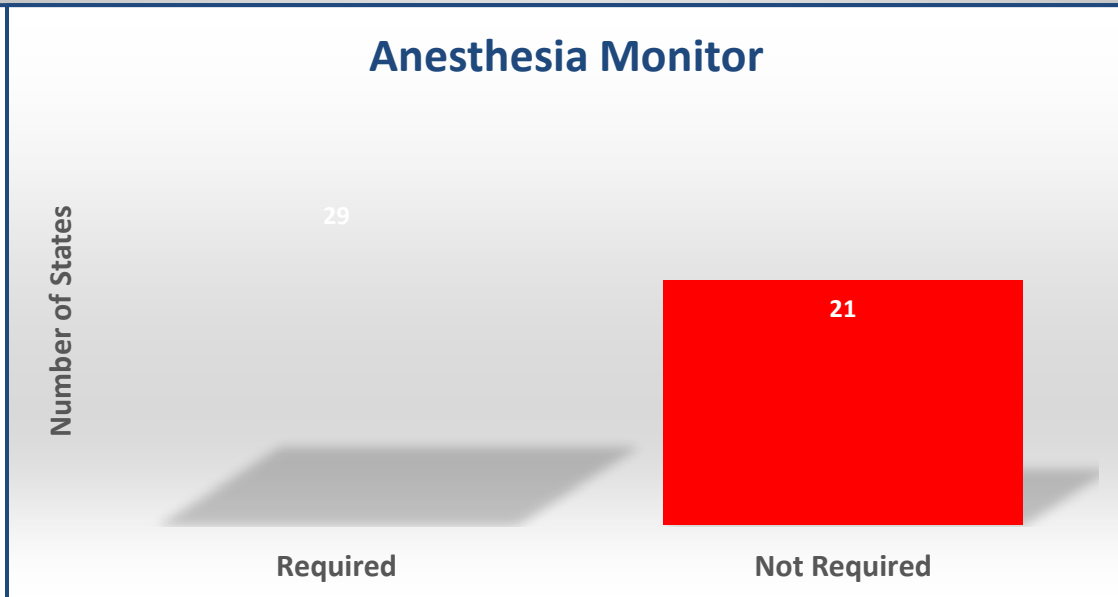
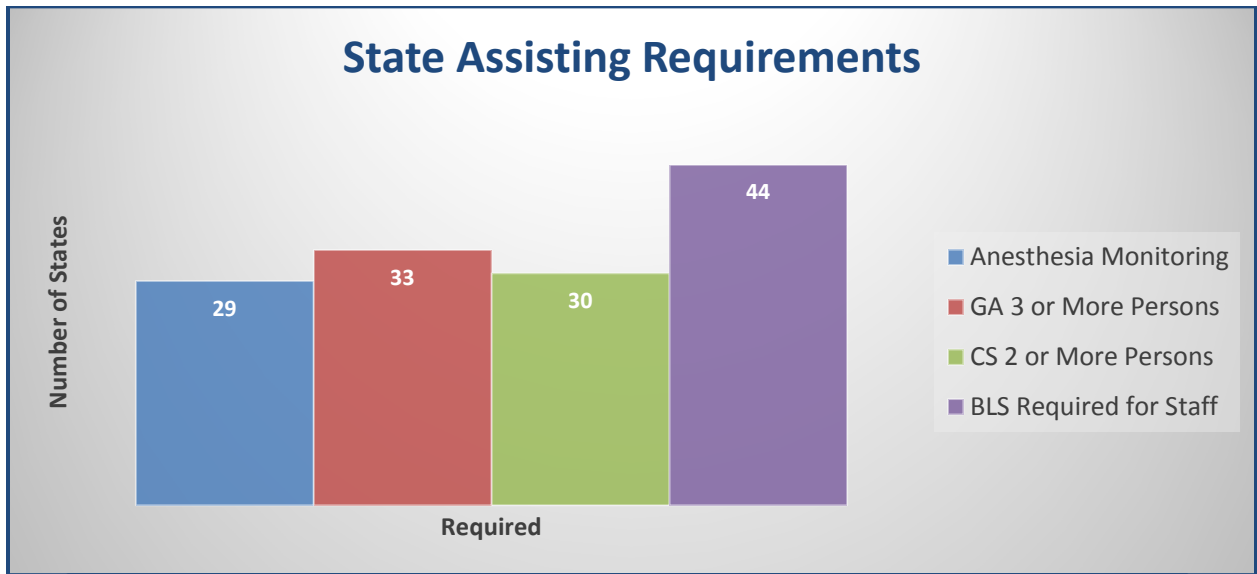


- 9. Pulse oximeter.
- 10. Capnograph and temperature device. A capnograph and temperature measuring device are required for the intubated patient receiving general anesthesia.

## Dental Assistants

### Personnel

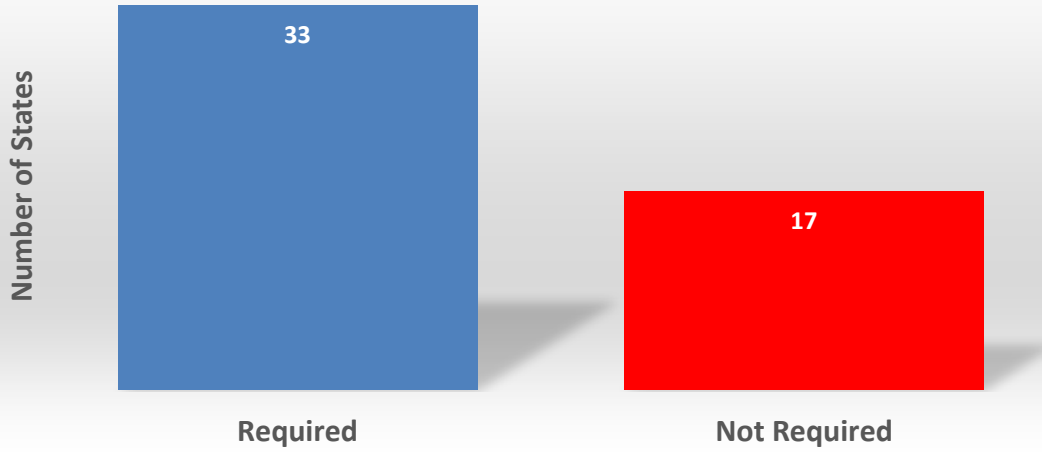
California does not presently specify how many staff are required for either general anesthesia or moderate sedation but patients must be monitored at all times



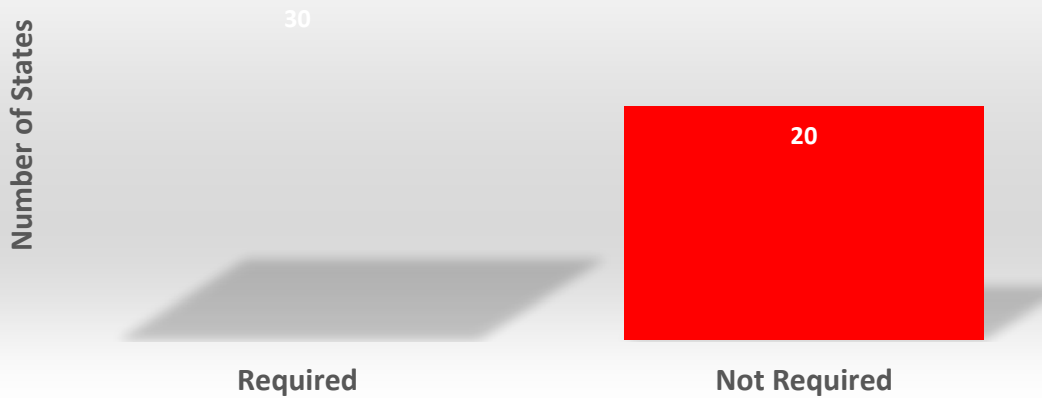
An anesthesia monitor is not presently required in California. The dentist is responsible for the competency of staff

Number of staff required

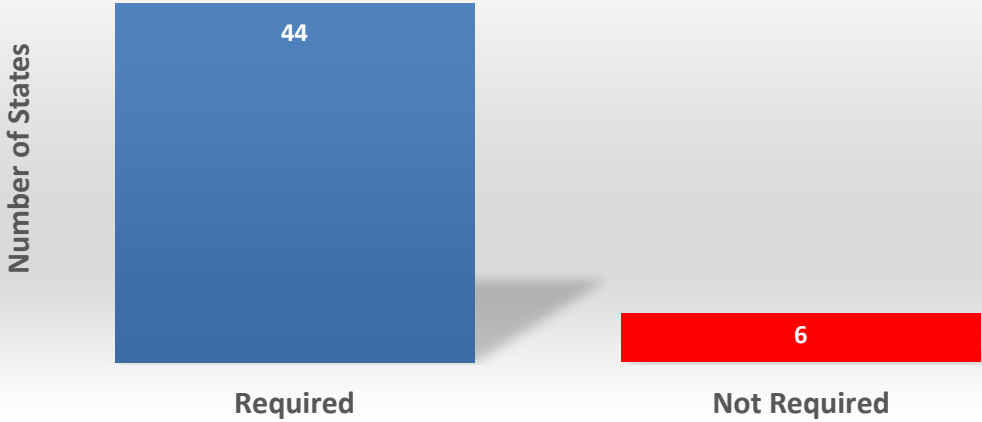
**General Anesthesia - 3 or More Persons**



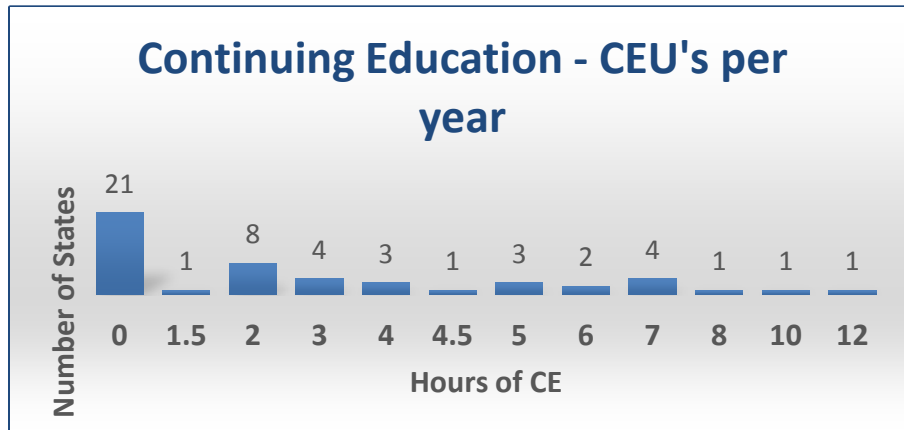
**Moderate Sedation - 2 or More Persons**



# BLS Required For Staff



## Continuing education



**California requires 25 units of continuing education per 2 year renewal cycle, the most of any state**

### **Pediatric sedation requirements**

Individual states have taken different approaches to the regulation of pediatric sedation. Twenty five states, including California have special requirements for young patients. California requirements apply to patients age 13 or under. An increasing number of states have adopted pediatric sedation educational requirements, equipment requirements, and permits over the past 10 years. All states regulate moderate sedation and deep sedation/GA, regardless of route of administration.

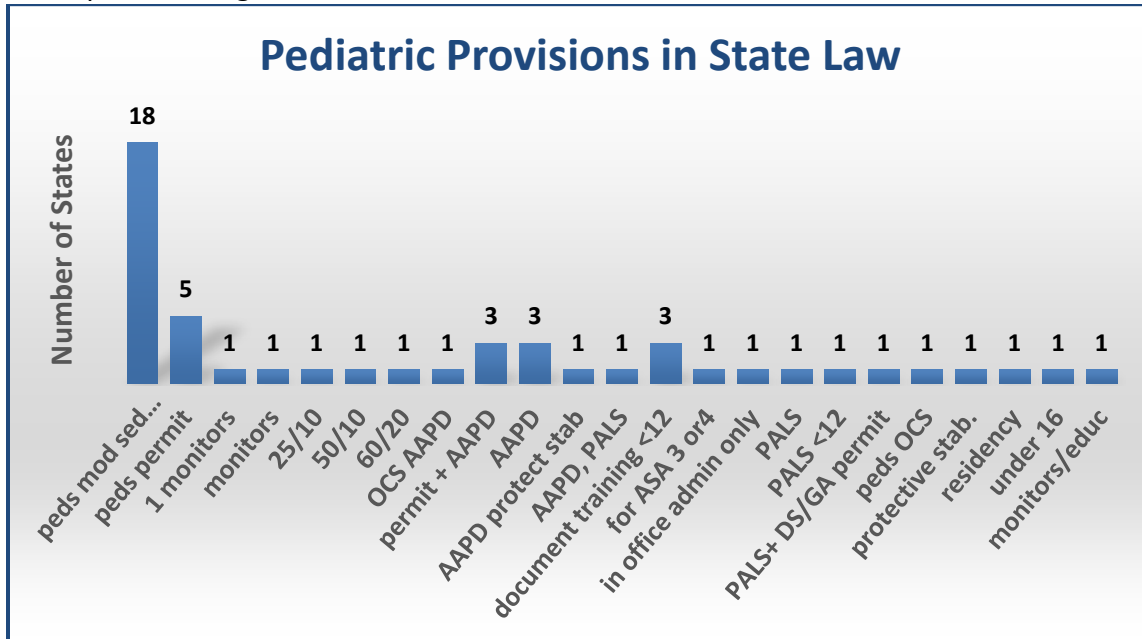
Ten states (California, Colorado, Florida, Georgia, Kentucky, Louisiana, Missouri, Mississippi, North Carolina and Oklahoma) require permits for sedating pediatric patients.

Sixteen states require specific training, some in addition to adult sedation training, to administer moderate/conscious sedation to pediatric patients.

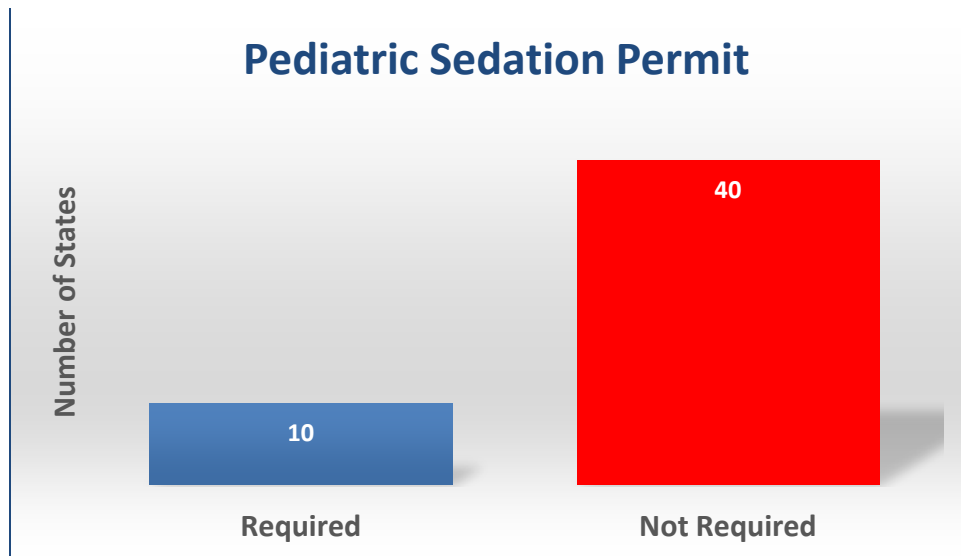
Approximately twenty nine states have specific requirements for pediatric sedation administered by the oral route.

States differ in their definition of the pediatric patient. Several states define the pediatric patient as being under the age of 12 consistent with ADA Guidelines; however other states use 13, 14, 16 and 18 years of age. Most states, including California, specify that the practitioner must have appropriately sized equipment for pediatric patients. In some states ACLS certification is deemed sufficient for treating pediatric patients; Twenty states currently require PALS certification. California does not presently require certification in PALS.

Although ten states have adopted the AAP-AAPD Guidelines, these usually apply to minimal and moderate sedation. Most states do not have specific requirements for the administration of deep sedation/general anesthesia to children.



OCS = oral conscious sedation; 25/10 etc. = classroom hours/supervised cases; PALS= pediatric advanced life support course; all numbers are approximate.





## Appendix 2

### Contents

#### **Comparison of California requirements for minimal, moderate and deep sedation/general anesthesia with American Dental Association Guidelines<sup>1</sup> and American Academy of Pediatrics – American Academy of Pediatric Dentistry Guidelines<sup>2</sup>**

Table 1.....	4
California definitions compared to ADA and ADA-AAPD Guidelines.....	4
Table 2.....	8
Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia.....	8
Continuing Education – State Requirements.....	12
Table 3.....	16
Pre operative evaluation requirements for minimal sedation, moderate sedation deep sedation and general anesthesia.....	16
Table 4.....	20
Personnel Requirements – Clinical Guidelines - Comparison of CA, ADA, and AAP-AAPD Guidelines.....	20
Sedation and Anesthesia Assisting Requirements in the 50 States.....	22
Table 5.....	25
Facility Requirements - Clinical Guidelines – Comparison of California, ADA and AAP-AAPD Guidelines .	25
Table 6. Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia.....	27
State Requirements.....	32
Table 7.....	33
Record Requirements - Clinical Guidelines for Minimal sedation, Moderate sedation, Deep Sedation, and General Anesthesia.....	33
Table 8.....	36
Emergency drugs - California sedation laws compared to ADA and ADA-AAPD Guidelines.....	36

<sup>1</sup> American Dental Association. (2012). Guidelines for the Use of Sedation and General Anesthesia by Dentists. In *Society* (Vol. 80, pp. 75–106). <http://doi.org/10.1112/S0024611500012132>

<sup>2</sup> American Academy of Pediatric Dentistry, “American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures”, adopted 2006, affirmed 2011.  
[http://www.aapd.org/media/Policies\\_Guidelines/G\\_Sedation.pdf](http://www.aapd.org/media/Policies_Guidelines/G_Sedation.pdf)

Table 9..... 38

State Mandated Office Inspection Requirements ..... 38

**1. California office inspection laws** ..... 38

**2. Summary of Requirements in 50 states** ..... 41

Table 10..... 43

Pediatric Sedation Laws for the 50 States – Summary ..... 43



Table 1

California definitions compared to ADA and ADA-AAPD Guidelines

<p>California requirements for minimal sedation, moderate sedation and general anesthesia</p> <p>California law has specific requirements for pediatric patients for oral (moderate) conscious sedation only.(age 13 and under)</p>	<p>ADA Guidelines for use of sedation and general anesthesia by dentists; For pediatric patients ADA supports AAP-AAPD Guidelines (age 12 and under)</p>	<p>AAP-AAPD Guidelines exclusively for monitoring and management of pediatric patients; (age 21 and under)</p>
	<p><b>Minimal Sedation</b></p>	
<p>Minimal sedation not defined in CA Law. See BPC 1647, Conscious Sedation and BPC 1647.10 Use of Oral Conscious Sedation for Pediatric patients; 1647.18 Use of Oral Conscious Sedation for Adult Patients.</p>	<p>“A minimally depressed level of consciousness produced by a pharmacological method, that retains the patient’s ability to independently and continuously maintain an airway and respond <i>normally</i> to tactile stimulation and verbal command.”</p> <p>“Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.”</p> <p>“The drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.</p> <p>The ADA Guidelines add a definition of “combination inhalation-enteral conscious sedation” for when the intent is anxiolysis only. When the intent is conscious (moderate) sedation that definition applies.</p>	<p><i>Minimal sedation</i> (old terminology <i>anxiolysis</i>): a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.</p>

	<b>Oral Conscious Sedation</b>	
<p><b>oral conscious sedation (pediatric and adult)</b> see BPC 1674.10</p> <p><b>Oral conscious sedation means</b> a minimally depressed level of consciousness produced by oral medication that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command."</p> <p>"The drugs and techniques used in oral conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli would not be considered to be in a state of oral conscious sedation."</p>	<p><i>Author's note: The ADA Guidelines include definitions of both conscious sedation and moderate sedation, and gives clinical guidelines for each. However the preferred term appears to be moderate sedation because it is accompanied by clinical guidelines.</i></p>	
	<b>Moderate Sedation</b>	
<p><b>CA term is "conscious sedation"</b> BPC 1647.1</p> <p>Conscious sedation means a minimally depressed level of consciousness produced by a pharmacologic or nonpharmacologic method, or a combination thereof, that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command."</p> <p>Conscious sedation does not include that administration of oral medication or the administration of a mixture of nitrous oxide and oxygen, whether alone or with each other.</p>	<p>The term "conscious sedation" has been replaced by the ADA with the term "moderate sedation", defined as "a drug-induced depression of consciousness during which patients respond <i>purposefully</i> to verbal commands, either alone or accompanied by light tactile stimulation."</p> <p>"No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained."</p> <p>"Drugs or techniques should maintain a margin of safety wide enough to render unintended loss</p>	<p>Moderate sedation (old terminology conscious sedation or sedation/analgesia): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands (eg, <i>open your eyes</i> either alone or accompanied by light tactile stimulation—a light tap on the shoulder or face, not a sternal rub). For older patients, this level of sedation implies an interactive state; for younger patients, age-appropriate behaviors (eg, crying) occur and are expected. Reflex withdrawal, although a normal response to a painful stimulus, is not considered as the only age-appropriate</p>

<p>The drugs and techniques used in conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely.</p> <p>For the very young or handicapped, incapable of the usual verbal response, a minimally depressed level of consciousness should be maintained.</p> <p>Further, patients whose only response is reflex withdrawal from painful stimuli shall not be considered to be in a state of conscious sedation.</p>	<p>of consciousness unlikely.”</p> <p>“Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist.”</p> <p>“A patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.</p> <p>The ADA Guidelines also include the following cautionary statement:</p> <p>“Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.”</p> <p>For all levels of sedation, the practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.</p>	<p>purposeful response (eg, it must be accompanied by another response, such as pushing away the painful stimulus so as to confirm a higher cognitive function).With moderate sedation, no intervention is required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. However, in the case of procedures that may themselves cause airway obstruction (eg, dental or endoscopic), the practitioner must recognize an obstruction and assist the patient in opening the airway. If the patient is not making spontaneous efforts to open his/her airway so as to relieve the obstruction, then the patient should be considered to be deeply sedated.</p>
	<b>Deep sedation</b>	
<p>Deep Sedation in California is described in BPC 1647 (c) as part of a continuum for which the educational standards for general anesthesia should be applied. Deep sedation is not otherwise defined in the California law.</p>	<p>The ADA defines deep sedation as “- a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require</p>	<ul style="list-style-type: none"> <li>• <i>Deep sedation</i> (deep sedation/analgesia): a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully (see discussion of reflex withdrawal above) after repeated verbal or painful stimulation (eg,</li> </ul>

	<p>assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.</p> <p>The ADA provides identical clinical guidelines for deep sedation or general anesthesia.</p>	<p>purposefully pushing away the noxious stimuli). The ability to independently maintain ventilator function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. A state of deep sedation may be accompanied by partial or complete loss of protective airway reflexes.</p>
	<b>General Anesthesia</b>	
<p>Defined as a “controlled state of depressed consciousness or unconsciousness, accompanied by a partial or complete loss of protective reflexes, produced by pharmacologic or non-pharmacologic method, or a combination thereof.” (BPC 1646)</p>	<p>A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.</p>	<p><i>General anesthesia:</i> a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.</p>
<p>CA requires a pediatric oral (moderate) conscious sedation permit for children 13 or under</p>	<p>Pediatrics</p> <p>For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.</p>	

Table 2

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia

California requirements for moderate sedation and general anesthesia	ADA Guidelines for use of sedation and general anesthesia by dentists	AAP-AAPD Guidelines for monitoring and management of pediatric patients
	<b>Educational Requirements</b>	
	<b>Minimal Sedation</b>	
<p>Minimal Sedation is not specifically defined in California sedation laws.</p> <p>Training in minimal sedation, including the administration of a mixture of nitrous oxide and oxygen, either alone or in combination with minimal oral sedation, may be taught to the level of basic competency at the predoctoral ( dental school) level.</p> <p>(see ADA Educational Guidelines)</p>	<p>The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage any emergencies that might arise as a consequence of treatment. Predoctoral dental students must complete a course in Basic Life Support for including a “hands on” component. Such courses should be AHA or ARC approved.</p> <p>Minimal sedation requires</p> <p>a. training to the level of competency in minimal sedation consistent with that prescribed in the <i>ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students</i>, or a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the <i>ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students</i> at the time training was commenced,</p> <p>or</p> <p>b. an equivalent advanced education program accredited by the ADA Commission on Dental Accreditation.</p>	<p>No specific educational requirements are provided in these guidelines, however personnel qualifications are stated.</p> <p>“The practitioner responsible for the treatment of the patient and/or the administration of drugs for sedation must be competent to use such techniques, to provide the level of monitoring provided in this guideline, and to manage complications of these techniques (ie, to be able to rescue the patient). Because the level of intended sedation may be exceeded, the practitioner must be sufficiently skilled to provide rescue should the child progress to a level of deep sedation. The practitioner must be trained in, and capable of providing, at the minimum, bag-valve-mask ventilation so as to be able to oxygenate a child who develops airway obstruction or apnea. Training in, and maintenance of, advanced pediatric airway skills is required; regular skills reinforcement is strongly encouraged.”</p>

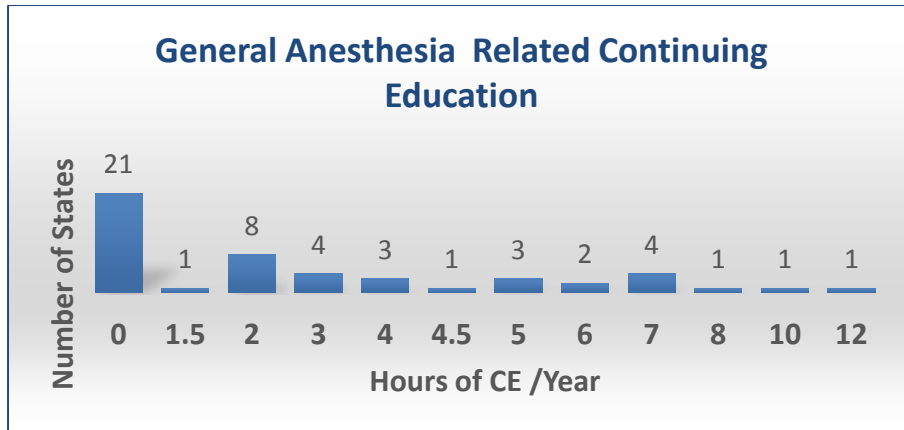
	<p><b>Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration:</b></p> <p>Current certification in Basic Life Support for Healthcare Providers</p> <ol style="list-style-type: none"> <li>1. Completion of a nitrous oxide competency course.</li> <li>2. While length of a course is only one of many factors, the course should include a minimum of <i>16 hours</i>, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated.</li> </ol> <p>Clinically-oriented experiences may include group observations on patients undergoing enteral and/or combination inhalation-enteral minimal sedation.</p> <p>Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies.</p> <p>The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted.</p> <p>The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course.</p> <p>Not intended for the management of sedation in children, which requires additional course content and clinical learning experience.</p>	
	<b>Moderate Sedation</b>	
<b>California Moderate enteral sedation courses for adults and minors</b>	<b>Moderate Enteral Sedation</b>	

<p>Completion of approved post doctoral or residency training; or, a board approved course that includes 25 hours of instruction including a clinical component utilizing at least one age-appropriate patient; training for either adult patients or minor patients (13 or younger); training requirements reference ADA, AAPD definitions of levels of sedation.( See BPC 1647.12; CCR 1044-1044.5.)</p>	<p>A minimum of <i>24 hours</i> of instruction, plus management of <i>at least 10 adult case experiences</i> by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These ten cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep to moderate sedation. Participants combining enteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course.</p> <p>Participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management. Clinical experience will be provided in managing healthy adult patients;</p> <p><b>this course in moderate enteral sedation is not designed for the management of children (aged 12 and under).</b> Additional supervised clinical experience is necessary to prepare participants to manage medically compromised adults and special needs patients. This course in moderate enteral sedation does not result in competency in moderate parenteral sedation. The faculty should schedule participants to return for additional didactic or clinical exposure if competency has not been achieved in the time allotted.</p>	<p>No specific educational requirements are provided in these guidelines, however personnel qualifications are stated.</p>
<p><b>Conscious Sedation (moderate IV sedation)</b></p>	<p><b>Moderate Parenteral Sedation</b></p>	<p><b>Moderate Sedation</b></p>

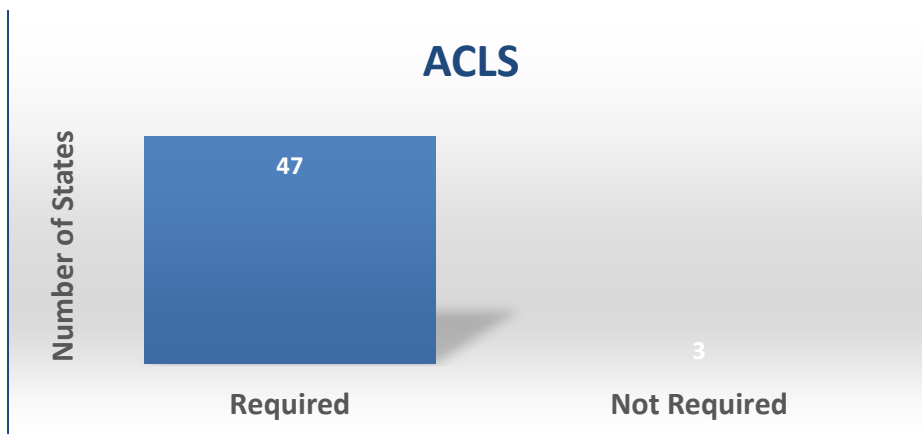
<p>At least 60 hours of instruction; Satisfactory completion of at least 20 cases of administration of conscious sedation for a variety of dental procedures.</p> <p>Course must comply with the requirements of the <i>Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry</i> of the American Dental Association (see BPC 1647.3)</p>	<p>A minimum of 60 hours of instruction plus management of at least 20 patients using the intravenous route; clinical experience in managing a compromised airway is critical to prevention of emergencies;</p> <p>Management of children and medically compromised adults requires additional experience; course completion does not result in clinical competency</p>	<p>The practitioner must be competent to use such techniques, to provide the level of monitoring provided in this guideline, and to manage complications of these techniques (ie, to be able to rescue the patient). (ed. Specific educational requirements are not described.)</p>
<p><b>General Anesthesia</b></p>	<p><b>Deep Sedation or General Anesthesia</b></p>	<p><b>Deep Sedation</b></p>
<p>Completion of a residency program in general anesthesia of not less than one calendar year, that is approved by the board; or a graduate program in oral and maxillofacial surgery which has been approved by the Commission on Dental Accreditation. (CCR 1043) ( A dentist who orders administration of anesthesia by a nurse anesthetist must meet the requirements for California general anesthesia permit.(BPC 2827).</p>	<p><b>C. Deep Sedation or General Anesthesia</b> 1.Completion of an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with these guidelines; and</p> <p>2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support (BLS) Course for the Healthcare Provider.</p>	<p>Ed. Specific educational requirements are not addressed in this document</p> <p>At least one individual must be present who is trained in, and capable of, providing advanced pediatric life support, and who is skilled in airway management and cardiopulmonary resuscitation; training in pediatric advanced life support is required.</p>



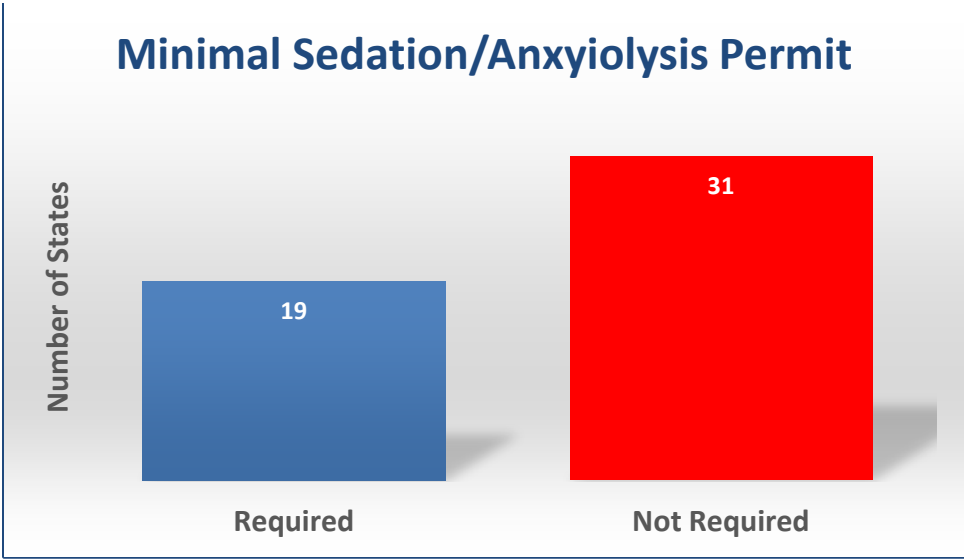
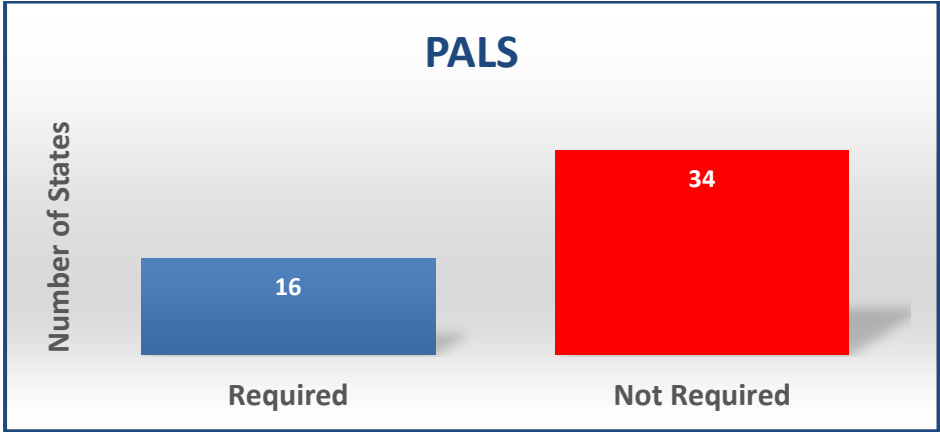
## Continuing Education – State Requirements



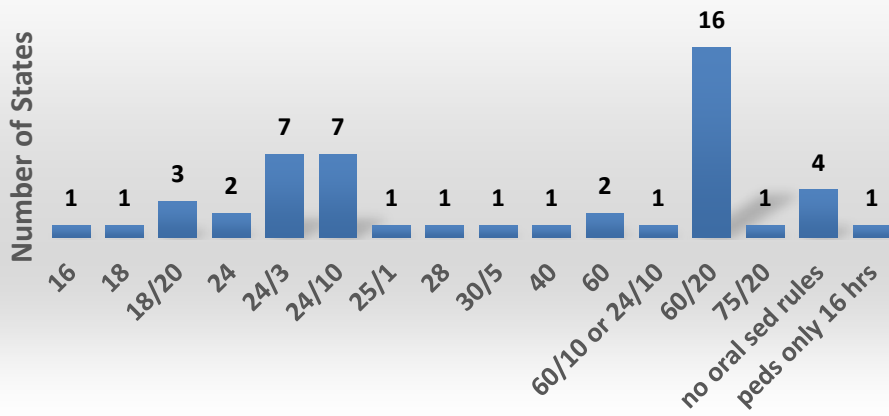
### ACLS for General Anesthesia Permits



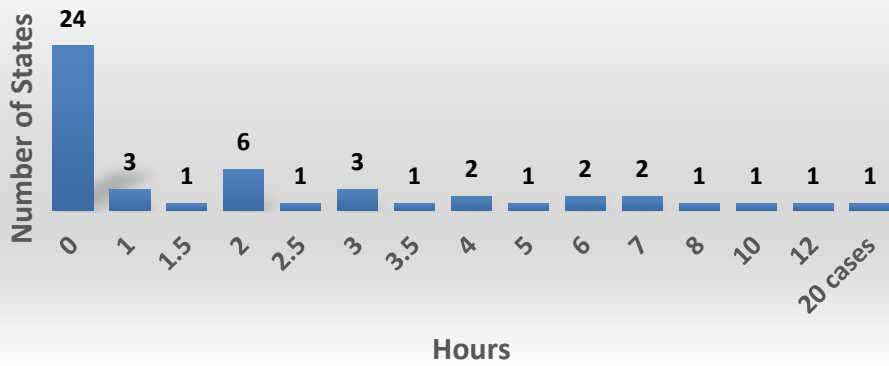
**Pediatric Advanced Life Support for General Anesthesia Permit Holders**



### Moderate Oral Sedation Course Requirements hours/cases



### Sedation Related Continuing Education Hours/Year



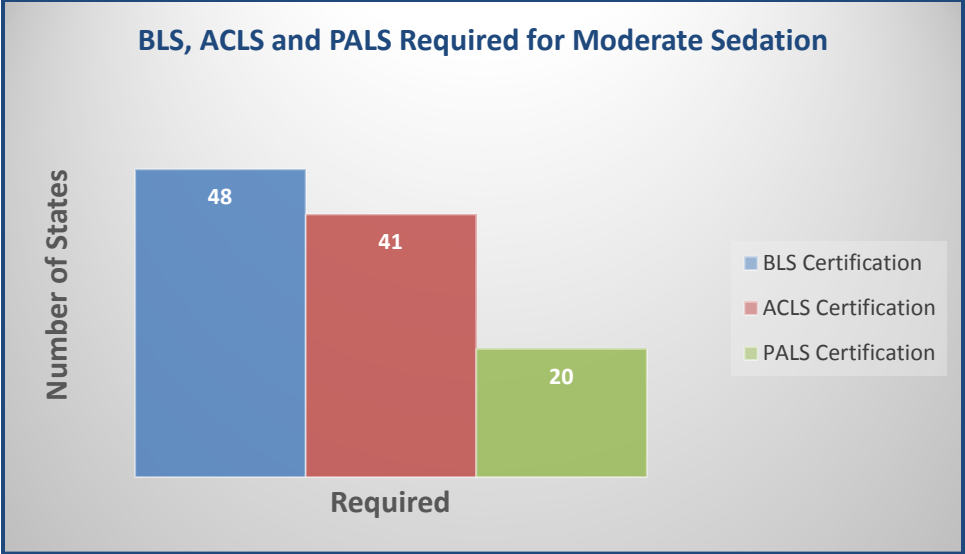


Table 3.

Pre operative evaluation requirements for minimal sedation, moderate sedation deep sedation and general anesthesia

	ADA Guidelines	AAP-AAPD Guidelines
The term Minimal sedation is not used in CA. Laws related to oral moderate sedation apply (CCR sec. 1044)	<b>Minimal sedation</b>	General Guidelines are provided for all levels of sedation
<p><b>Preoperative evaluation</b></p> <p>Adequate medical history and physical evaluation records updated prior to each administration of oral conscious sedation. Such records shall include, but are not limited to an assessment including at least visual examination of the airway, the age, sex, weight, physical status (American Society of Anesthesiologists Classification), and rationale for sedation of the minor or adult patient. (CCR 1043.3 (i))</p> <p>Written informed consent must be obtained for all patients undergoing general anesthesia or conscious sedation, or as appropriate, from the parent or legal guardian of the patient. (BPC 1682 (d))</p> <p><b>There is no specific requirement for preoperative dietary precautions.</b></p>	<p>Preoperative evaluation and preparation</p> <ol style="list-style-type: none"> <li>1. In healthy or medically stable individuals (ASA I, II) a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.</li> <li>2. Pre-Operative Preparation <ul style="list-style-type: none"> <li>• The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.</li> <li>• Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.</li> <li>• Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.</li> <li>• A focused physical evaluation must be performed</li> </ul> </li> </ol>	<p><b>Health evaluation</b></p> <p>Age and weight.</p> <ul style="list-style-type: none"> <li>• Health history, including: 1) allergies and previous allergic or adverse drug reactions, 2) medication/drug history. 3) relevant diseases, physical abnormalities, and neurologic impairment that might increase the potential for airway obstruction, such as a history of snoring or obstructive sleep apnea, 4) pregnancy status, 5) a summary of previous relevant hospitalizations, 6) history of sedation or general anesthesia and any complications or unexpected responses, and 7) relevant family history, particularly related to anesthesia.</li> <li>• Review of systems with a special focus on abnormalities of cardiac, pulmonary, renal, or hepatic function. Vital signs, including heart rate, blood pressure, respiratory rate, and temperature</li> <li>• Physical examination, including a focused evaluation of the airway (tonsillar hypertrophy, abnormal anatomy)</li> <li>• Physical status</li> </ul>

	<p>as deemed appropriate.</p> <ul style="list-style-type: none"> <li>• Preoperative dietary restrictions must be considered based on the sedative technique prescribed.</li> <li>• Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.</li> </ul>	<p>evaluation [ASA classification</p> <ul style="list-style-type: none"> <li>• Name, address, and telephone number of the child's medical home.</li> </ul> <p>Dietary precautions  <b>Dietary precautions</b>  Before sedation, the practitioner should evaluate preceding food and fluid intake. It is likely that the risk of aspiration during procedural sedation differs from that during general anesthesia involving tracheal intubation or other airway manipulation. However, because the absolute risk of aspiration during procedural sedation is not yet known, guidelines for fasting periods before elective sedation generally should follow those used for elective general anesthesia. For emergency procedures in children who have not fasted, the risks of sedation and the possibility of aspiration must be balanced against the benefits of performing the procedure promptly <b>Further research is needed to better elucidate the relationships between various fasting intervals and sedation complications</b></p>
<b>Conscious (Moderate) Sedation</b>	<b>Moderate Sedation</b>	<b>Moderate Sedation</b> See above section
Adequate medical history and physical evaluation records updated prior to each administration of general anesthesia or conscious sedation. Such records shall include, but are not limited to the recording of the age, sex, weight, physical status (American Society of Anesthesiologists	<p>Patient Evaluation</p> <p>In healthy or medically stable individuals (ASA I, II) evaluation should consist of at least a review of their current medical history and medication use. However, patients with significant medical considerations (e.g., ASA III, IV) may require</p>	

<p>Classification), medication use, any known or suspected medically compromising conditions, rationale for sedation of the patient, and visual examination of the airway, and for general anesthesia only, auscultation of the heart and lungs as medically required.(CCR 1043.3 (i))</p> <p><b>There are no specific requirements for preoperative dietary restrictions.</b></p> <p>A written informed consent must be signed by the patient or guardian, see BPC 1682 (d)</p>	<p>consultation with their primary care physician or consulting medical specialist.</p> <p>2. Pre-operative Preparation</p> <ul style="list-style-type: none"> <li>• The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.</li> <li>• Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.</li> <li>• Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.</li> <li>• A focused physical evaluation must be performed as deemed appropriate.</li> <li>• <b>Preoperative dietary restrictions must be considered based on the sedative technique prescribed.</b></li> <li>• Pre-operative verbal or written instructions must be given to the patient, parent, escort, guardian or care giver.</li> </ul>	
<p><b>General Anesthesia</b></p>	<p><b>Deep Sedation or General Anesthesia</b></p>	<p><b>Deep Sedation</b></p>
<p><b>no specific dietary restrictions</b></p> <p><b>Equipment for an IV must be available, but does not need to be established. Dentist discretion advised for cases where it may be difficult or impossible to establish IV access.</b></p>	<p>1. Patient Evaluation</p> <p>In healthy or medically stable individuals (ASA I, II) at least a review of their current medical history and medication use and NPO status. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting</p>	<p>Ed. See above section for health evaluation. This applies to all levels of sedation.</p>

	<p>medical specialist.</p> <p>2. Pre-operative Preparation</p> <ul style="list-style-type: none"> <li>• The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.</li> <li>• Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.</li> <li>• Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.</li> <li>• A focused physical evaluation must be performed as deemed appropriate.</li> <li>• <b>Preoperative dietary restrictions must be considered based on the sedative/anesthetic technique prescribed.</b></li> <li>• Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.</li> <li>• <b>An intravenous line, which is secured throughout the procedure, must be established</b> except as provided in part IV. C.6. Pediatric and Special Needs Patients.</li> </ul>	



Table 4.

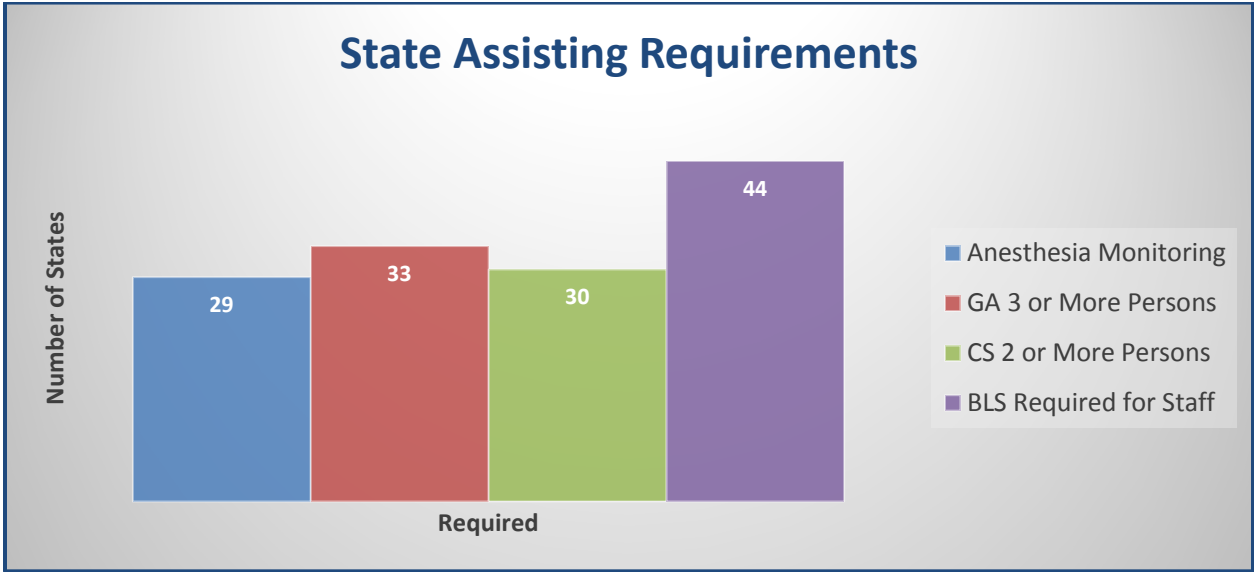
Personnel Requirements – Clinical Guidelines - Comparison of CA, ADA, and AAP-AAPD Guidelines

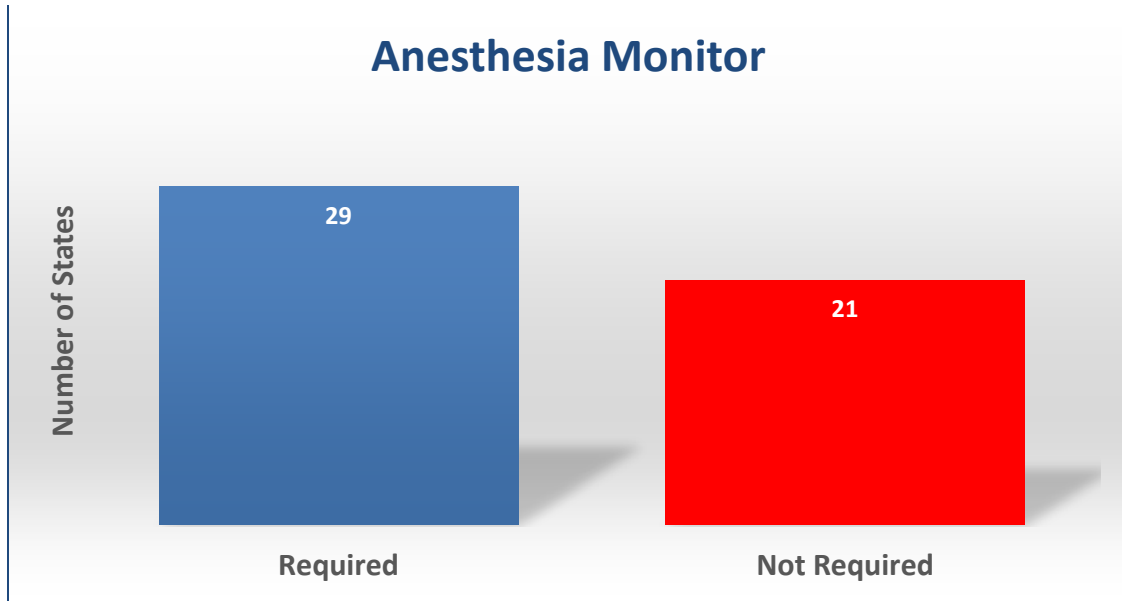
California	ADA Guidelines	AAP-AAPD Guidelines
<b>Minimal sedation</b>	<b>Minimal sedation</b>	<b>Minimal sedation</b>
	At least one additional person trained in BLS + dentist	Children who have received minimal sedation generally will not require more than observation and intermittent assessment of their level of sedation. Some children will become moderately sedated despite the intended level of minimal sedation; should this occur, then the guidelines for moderate sedation apply.
<b>Moderate sedation</b>	<b>Moderate sedation</b>	<b>Moderate sedation</b>
<p>BPC 1682</p> <p>Each patient is continuously monitored on a one-to-one ratio while sedated by either the dentist or another licensed health professional authorized by law to administer conscious sedation or general anesthesia.</p> <p>The patient must be closely monitored by licensed health professionals experienced in the care and resuscitation of patients recovering from conscious sedation or general anesthesia.</p> <p>If one licensed professional is responsible for the recovery care of more than one patient at a time, all of the patients shall be physically in the same room to allow continuous visual contact with all patients and the patient to recovery staff ratio should not exceed three to one.</p>	At least one person trained in BLS for providers+dentist	The use of moderate sedation shall include provision of a person, in addition to the practitioner, whose responsibility is to monitor appropriate physiologic parameters and to assist in any supportive or resuscitation measures, if required. This individual may also be responsible for assisting with interruptible patient-related tasks of short duration. <sup>44</sup> This individual must be trained in and capable of providing pediatric basic life support. The support person shall have specific assignments in the event of an emergency and current knowledge of the emergency cart inventory. The practitioner and all ancillary personnel should participate in periodic reviews and practice drills of the facility's emergency protocol to ensure proper function of the equipment and coordination of staff roles in such emergencies

<p>Staff must be certified in basic cardiac life support (CPR) and recertified</p>		
	<p>A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.</p>	<p>One person, in addition to the practitioner, whose responsibility is to monitor appropriate physiologic parameters and to assist in any supportive or resuscitation measures, if required. This individual may also be responsible for assisting with interruptible patient-related tasks of short duration. This individual must be trained in and capable of providing pediatric basic life support. The support person shall have specific assignments in the event of an emergency and current knowledge of the emergency cart inventory. The practitioner and all ancillary personnel should participate in periodic reviews and practice drills of the facility's emergency protocol to ensure proper function of the equipment and coordination of staff roles in such emergencies.</p>
<p><b>Deep sedation/general anesthesia</b></p>	<p><b>Deep sedation/general anesthesia</b></p>	<p><b>Deep sedation/GA</b></p>
<p>Same as moderate sedation</p>	<p>A minimum of three (3) individuals must be present.</p> <ul style="list-style-type: none"> <li>• A dentist qualified in accordance with Part III. C. of these Guidelines to administer the deep sedation or general anesthesia.</li> <li>• Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider.</li> <li>• When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.</li> </ul>	<p>There must be one person available whose only responsibility is to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation and to either administer drugs or direct their administration. At least one individual must be present who is trained in, and capable of, providing advanced pediatric life support, and who is skilled in airway management and cardiopulmonary resuscitation; training in pediatric advanced life support is required.</p>

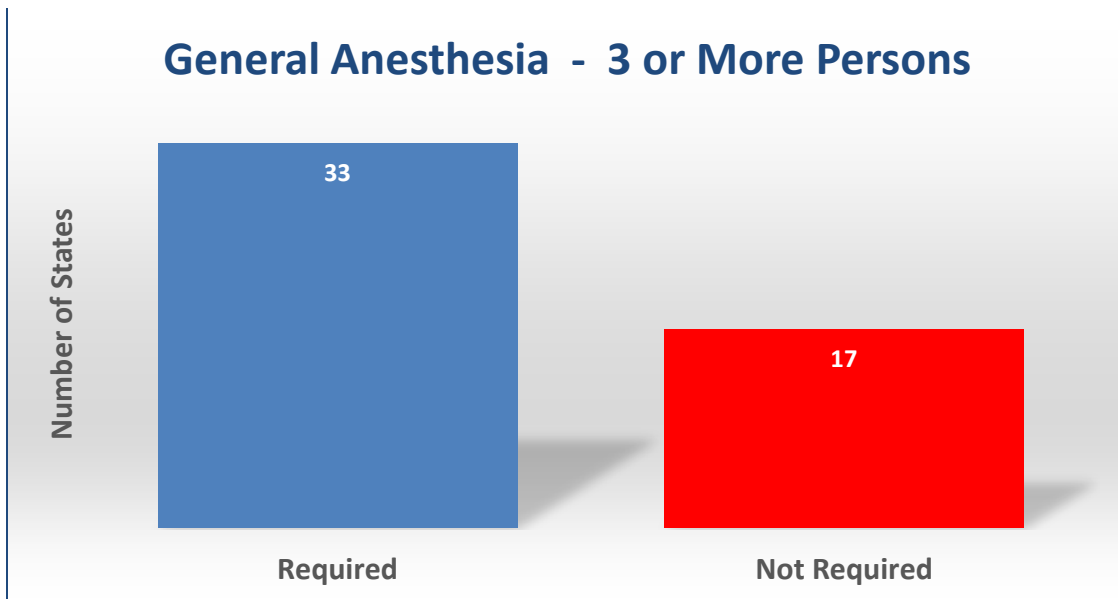
	<p>A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.</p>	
--	---	--

## Sedation and Anesthesia Assisting Requirements in the 50 States

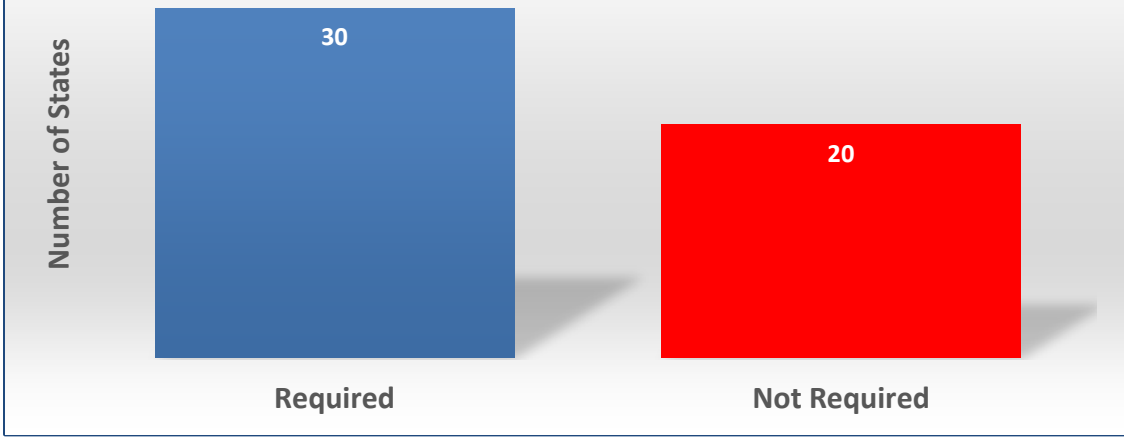




## Sedation and Anesthesia Assisting Requirements in the 50 States



### Conscious Sedation - 2 or More Persons



### Sedation and Anesthesia Assisting Requirements in the 50 States

#### BLS Required For Staff

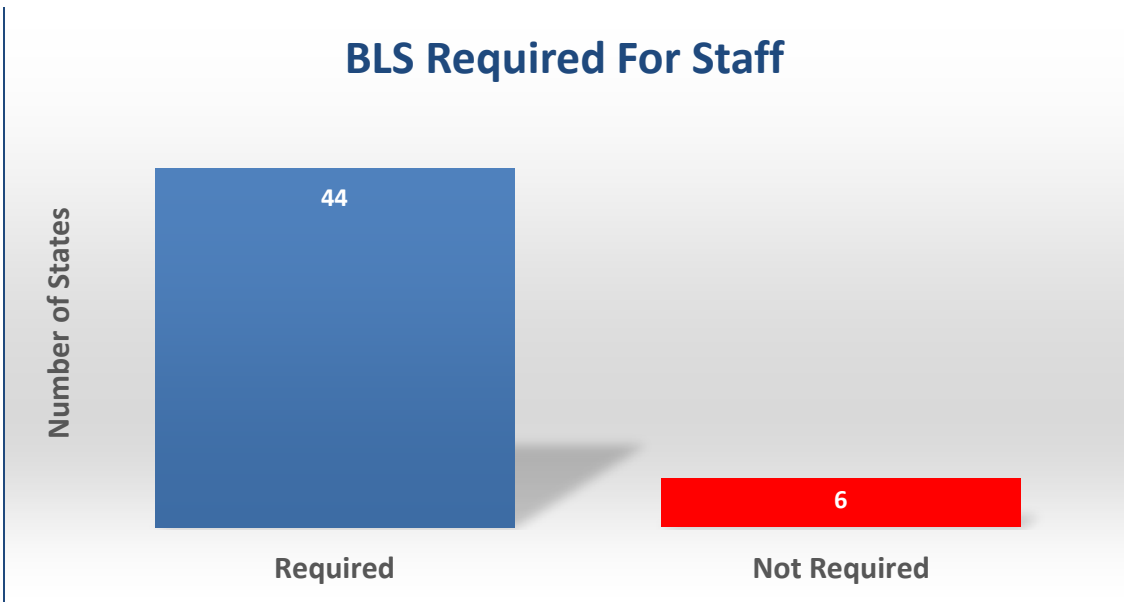


Table 5.

Facility Requirements - Clinical Guidelines – Comparison of California, ADA and AAP-AAPD Guidelines

California Requirements	ADA Guidelines	AAP-AAPD Guidelines
<p><b>Facilities</b></p> <p><b>See CCR 1044.5 Facility and Equipment Standards – these are the same for all levels of sedation and anesthesia</b></p> <p>(a) Office Facilities and Equipment. The following office facilities and equipment shall be available and shall be maintained in good operating condition:</p> <p>(1) An operating theater large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient.</p> <p>(2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation.</p> <p>(3) A lighting system which is adequate to permit evaluation of the patient’s skin and mucosal color and a backup lighting system which is battery powered and of sufficient intensity to permit</p>	<p>Facility requirements not specifically stated, except as listed under equipment requirements below.</p> <p>A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.</p> <ul style="list-style-type: none"> <li>• When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.</li> <li>• An appropriate scavenging system must be available if gases other than oxygen or air are used.</li> </ul>	<p><b>Facilities</b></p> <p>The practitioner who uses sedation must have immediately available facilities, personnel, and equipment to manage emergency and rescue situations. The most common serious complications of sedation involve compromise of the airway or depressed respirations resulting in airway obstruction, hypoventilation, hypoxemia, and apnea. Hypotension and cardiopulmonary arrest may occur, usually from inadequate recognition and treatment of respiratory compromise. Other rare complications may also include seizures and allergic reactions. Facilities providing pediatric sedation should monitor for, and be prepared to treat, such complications.</p>

<p>completion of any operation underway at the time of general power failure.</p> <p>(4) Suction equipment which permits aspiration of the oral and pharyngeal cavities. A backup suction device which can operate at the time of general power failure must also be available.</p> <p>(5) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of allowing the administering of greater than 90% oxygen at a 10 liter/minute flow at least sixty minutes (650 liter "E" cylinder) to the patient under positive pressure, together with an adequate backup system which can operate at the time of general power failure.</p> <p>(6) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating theater.</p>		

**Table 6. Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia**

California Requirements	ADA Guidelines	AAP-AAPD Guidelines
Oral Conscious Sedation	Minimal Sedation	All Levels of Sedation
<p>CCR 1044: An emergency cart or kit shall be available and readily accessible and shall include the necessary and appropriate drugs and age- and size-appropriate equipment to resuscitate a nonbreathing and unconscious patient and provide continuous support while the patient is transported to a medical facility. There must be documentation that all emergency equipment and drugs are checked and maintained on a prudent and regularly scheduled basis.</p> <p>Ancillary equipment, which must include the following, and be maintained in good operating condition:</p> <ul style="list-style-type: none"> <li>(1) Age-appropriate oral airways capable of accommodating patients of all sizes.</li> <li>(2) An age-appropriate sphygmomanometer with cuffs of appropriate size for patients of all sizes.</li> <li>(3) A precordial/pretracheal stethoscope.</li> <li>(4) A pulse oximeter</li> </ul>	<p><b>Monitoring:</b> A dentist, or at the dentist’s direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include:</p> <p><b>Oxygenation:</b></p> <ul style="list-style-type: none"> <li>• Color of mucosa, skin or blood must be evaluated continually.</li> <li>• Oxygen saturation by pulse oximetry may be clinically useful and should be considered.</li> </ul> <p><b>Ventilation:</b></p> <ul style="list-style-type: none"> <li>• The dentist and/or appropriately trained individual must observe chest excursions continually.</li> <li>• The dentist and/or appropriately trained individual must verify respirations continually.</li> </ul> <p><b>Circulation:</b></p> <ul style="list-style-type: none"> <li>• Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).</li> </ul>	<p><b>On-site monitoring and rescue equipment</b></p> <p>An emergency cart or kit must be immediately accessible. This cart or kit must contain equipment to provide the necessary age- and size-appropriate drugs and equipment to resuscitate a non breathing and unconscious child. The contents of the kit must allow for the provision of continuous life support while the patient is being transported to a medical facility or to an-other area within a medical facility.</p> <p>All equipment and drugs must be checked and maintained on a scheduled basis (see Appendices C and D for suggested drugs and emergency life support equipment to consider before the need for rescue occurs). Monitoring devices, such as electrocardiography (ECG) machines, pulse oximeters (with size-appropriate oximeter probes), end-tidal carbon dioxide monitors, and defibrillators (with size-appropriate defibrillator paddles), must have a safety and function check on a regular basis as required by local or state regulation.</p>



Conscious Sedation	Moderate sedation	
<p>1682 (c) Acts constituting unprofessional conduct:</p> <p>Any dentist with patients who are undergoing conscious sedation to fail to have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior equipment required by the board.</p> <p>BJC 1043.3</p> <p>(7) Ancillary equipment, which must include the following maintained in good operating condition:</p> <p>(A) Laryngoscope complete with adequate selection of blades and spare batteries and bulb. (This equipment is not required for conscious sedation.)</p> <p>(B) Endotracheal tubes and appropriate connectors. (This equipment is not required for conscious sedation.)</p> <p>(C) Emergency airway equipment (oral airways, laryngeal mask airways or combitubes, cricothyrotomy device).</p> <p>(D) Tonsillar or pharyngeal type suction tip adaptable to all office outlets.</p> <p>(E) Endotracheal tube forcep . (This equipment is not required for conscious sedation.)</p> <p>(F) Sphygmomanometer and stethoscope.</p> <p>(G) Electrocardioscope and defibrillator. (This equipment is not required for conscious sedation.)</p> <p>(H) Adequate equipment for the establishment of an intravenous infusion.</p> <p>(I) Precordial/pretracheal stethoscope.</p> <p>(J) Pulse oximeter.</p> <p>(K) Capnograph and temperature device. A capnograph and temperature measuring device are required for the intubated patient receiving general anesthesia. (This equipment is not required for conscious sedation.)</p>	<p>Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:</p> <p>Consciousness:</p> <ul style="list-style-type: none"> <li>• Level of consciousness (e.g., responsiveness to verbal command) must be continually assessed.</li> </ul> <p>Oxygenation:</p> <ul style="list-style-type: none"> <li>• Color of mucosa, skin or blood must be evaluated continually.</li> <li>• Oxygen saturation must be evaluated by pulse oximetry continuously.</li> </ul> <p>Ventilation:</p> <ul style="list-style-type: none"> <li>• The dentist must observe chest excursions continually.</li> <li>• The dentist must monitor ventilation. This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO<sub>2</sub> or by verbal communication with the patient.</li> </ul> <p>Circulation:</p> <ul style="list-style-type: none"> <li>• The dentist must continually evaluate blood pressure and heart rate (unless the patient is unable to tolerate and this is noted in the time-oriented anesthesia record).</li> </ul>	<p><b>S</b> =Size-appropriate <b>suction</b> catheters and a functioning <b>suction</b> apparatus (eg, Yankauer-type suction)</p> <p><b>O</b> = An adequate <b>oxygen</b> supply and functioning flow meters/other devices to allow its delivery</p> <p><b>A</b> = <b>Airway:</b> size-appropriate airway equipment [nasopharyngeal and oropharyngeal airways, laryngoscope blades (checked and functioning), endotracheal tubes, stylets, face mask, bag-valve-mask or equivalent device (functioning)]</p> <p><b>P</b> = <b>Pharmacy:</b> all the basic drugs needed to support life during an emergency, including antagonists as indicated</p> <p><b>M</b> = <b>Monitors:</b> functioning pulse oximeter with size-appropriate oximeter probes 141, 142 and other monitors as appropriate for the procedure (eg, noninvasive blood pressure, end-tidal carbon dioxide, ECG, stethoscope)</p> <p><b>E</b> = Special <b>equipment or drugs</b> for a particular case (eg, defibrillator)</p> <p>Appendix D includes a list of suggested drugs and equipment that MAY be needed to rescue a sedated patient.</p>

	<ul style="list-style-type: none"> <li>• Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.</li> </ul>	<p>Appendix D. Emergency Equipment† That May Be Needed to Rescue a Sedated Patient ‡</p> <p><b>Intravenous Equipment</b></p> <p>Assorted IV catheters (eg, 24-, 22-, 20-, 18-, 16-gauge)</p> <p>Tourniquets</p> <p>Alcohol wipes</p> <p>Adhesive tape</p> <p>Assorted syringes (eg, 1-, 3-, 5-, 10-mL)</p> <p>IV tubing</p> <p>Pediatric drip (60 drops/mL)</p> <p>Pediatric burette</p> <p>Adult drip (10 drops/mL)</p> <p>Extension tubing</p> <p>3-way stopcocks</p> <p>IV fluid</p> <p>Lactated Ringer solution</p> <p>Normal saline solution</p> <p>D<sub>5</sub> 0.25 normal saline solution</p> <p>Pediatric IV boards</p> <p>Assorted IV needles (eg, 25-, 22-, 20-, and 18-gauge)</p> <p>Intraosseous bone marrow needle</p> <p>Sterile gauze pads</p> <p><b>Airway Management Equipment</b></p> <p>Face masks (infant, child, small adult, medium adult, large adult)</p> <p>Breathing bag and valve set</p> <p>Oropharyngeal airways (infant, child, small adult, medium adult, large adult)</p> <p>Nasopharyngeal airways (small, medium, large)</p> <p>Laryngeal mask airways (1, 1.5, 2, 2.5, 3, 4, and 5)</p> <p>Laryngoscope handles (with extra batteries)</p> <p>Laryngoscope blades (with extra light bulbs)</p> <p>Straight (Miller) No. 1, 2, and 3</p> <p>Curved (Macintosh) No. 2 and 3</p> <p>Endotracheal tubes (2.5,</p>
--	---	--

		<p>3.0, 3.5, 4.0, 4.5, 5.0, 5.5, and 6.0 uncuffed and 6.0, 7.0, and 8.0 cuffed)</p> <p>Stylettes (appropriate sizes for endotracheal tubes)</p> <p>Surgical lubricant</p> <p>Suction catheters (appropriate sizes for endotracheal tubes)</p> <p>Yankauer-type suction</p> <p>Nasogastric tubes</p> <p>Nebulizer with medication kits</p> <p>Gloves (sterile and nonsterile, latex free)</p> <p>† The choice of emergency equipment may vary according to individual or procedural needs.</p> <p>‡ The practitioner is referred to the SOAPME acronym describe</p>
Conscious (Moderate) Sedation and General Anesthesia	Deep Sedation or General Anesthesia	Deep Sedation
<p>1682 (c) Acts constituting unprofessional conduct:</p> <p>Any dentist with patients who are undergoing conscious sedation to fail to have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior equipment required by the board.</p> <p>1043.3 Onsite inspections</p> <p>The following office facilities and equipment shall be available and shall be maintained in good operating condition:</p> <p>Ancillary equipment, which must include the following maintained in good operating condition:</p> <p>Ancillary Equipment:</p> <p>(K) Laryngoscope complete with adequate selection of blades and spare</p>	<p>Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:</p> <p>Oxygenation:</p> <ul style="list-style-type: none"> <li>• Color of mucosa, skin or blood must be continually evaluated.</li> <li>• <b>Oxygenation saturation must be evaluated continuously by pulse oximetry.</b></li> </ul> <p>Ventilation:</p> <ul style="list-style-type: none"> <li>• Intubated patient: End-tidal CO2 must be continuously monitored and evaluated.</li> <li>• <b>Non-intubated patient: Breath sounds via auscultation and/or</b></li> </ul>	<p>Equipment</p> <p>In addition to the equipment previously cited for moderate sedation, an electrocardiographic monitor and a defibrillator for use in pediatric patients should be readily available.</p> <p><b>Vascular Access</b></p> <p><b>Patients receiving deep sedation should have an intravenous line placed at the start of the procedure or have a person skilled in establishing vascular access in pediatric patients immediately available.</b></p>

<p>batteries and bulb. (This equipment is not required for conscious sedation.)</p> <p>(L) Endotracheal tubes and appropriate connectors. (This equipment is not required for conscious sedation.)</p> <p>(M) Emergency airway equipment (oral airways, laryngeal mask airways or combitubes, cricothyrotomy device).</p> <p>(N) Tonsillar or pharyngeal type suction tip adaptable to all office outlets.</p> <p>(O) Endotracheal tube forcep . (This equipment is not required for conscious sedation.)</p> <p>(P) Sphygmomanometer and stethoscope.</p> <p>(Q) Electrocardioscope and defibrillator. (This equipment is not required for conscious sedation.)</p> <p>(R) Adequate equipment for the establishment of an intravenous infusion.</p> <p>(S) Precordial/pretracheal stethoscope.</p> <p>(T) Pulse oximeter.</p> <p>(K) Capnograph and temperature device. A capnograph and temperature measuring device are required for the intubated patient receiving general anesthesia. (This equipment is not required for conscious sedation.)</p>	<p><b>end-tidal CO2 must be continually monitored and evaluated.</b></p> <ul style="list-style-type: none"> <li>• Respiration rate must be continually monitored and evaluated.</li> </ul> <p>Circulation:</p> <ul style="list-style-type: none"> <li>• The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.</li> <li>• The dentist must continually evaluate blood pressure.</li> </ul> <p>Temperature:</p> <ul style="list-style-type: none"> <li>• A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.</li> <li>• The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered</li> </ul> <p><b>An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.</b></p>	

## State Requirements

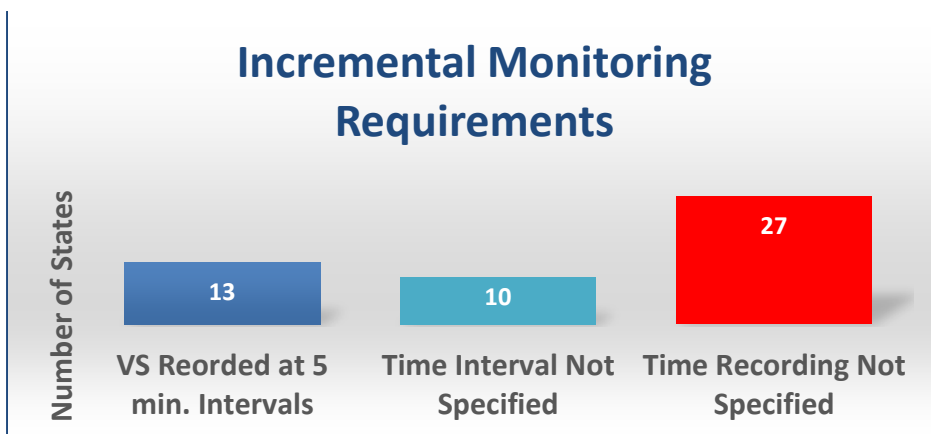
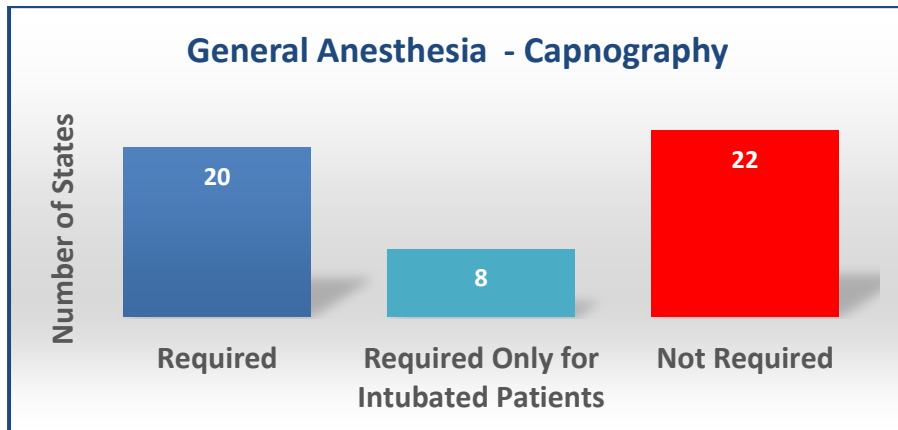
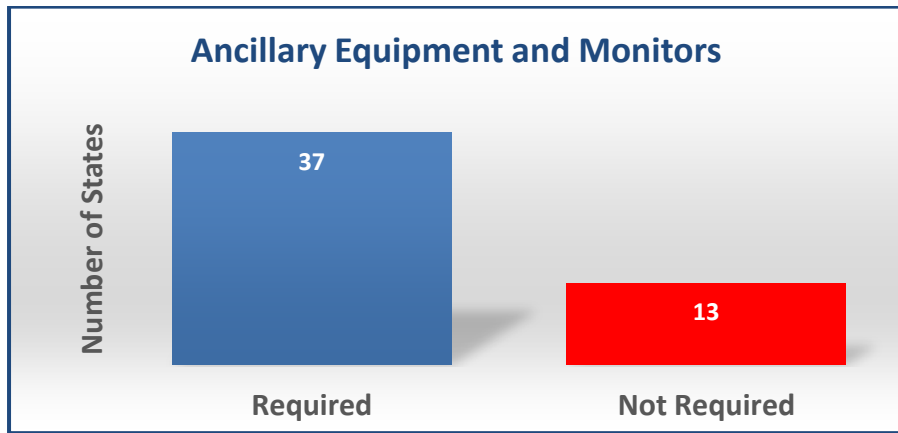


Table 7.

Record Requirements - Clinical Guidelines for Minimal sedation, Moderate sedation, Deep Sedation, and General Anesthesia

California Record Requirements	ADA Guidelines	AAP-AAPD Guidelines
Oral (Moderate) Conscious Sedation	Minimal Sedation	All levels of Sedation
<p>Oral conscious sedation records shall include baseline vital signs. If obtaining baseline vital signs is prevented by the patient's physical resistance or emotional condition, the reason or reasons must be documented. The records shall also include intermittent quantitative monitoring and recording of oxygen saturation, heart and respiratory rates, blood pressure as appropriate for specific techniques, the name, dose and time of administration of all drugs administered including local and inhalation anesthetics, the length of the procedure, any complications of oral sedation, and a statement of the patient's condition at the time of discharge. (CCR 1044.5)</p>	<p>Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored physiological parameters.</p>	<p><b>Documentation prior to treatment – see preoperative evaluation</b></p> <p><b>Documentation during treatment</b>                      The patient’s chart shall contain a time-based record that includes the name, route, site, time, dosage, and patient effect of administered drugs. Before sedation, a “time out” should be performed to confirm the patient’s name, procedure to be performed, and site of the procedure.</p> <p>During administration, the inspired concentrations of oxygen and inhalation sedation agents and the duration of their administration shall be documented. Before drug administrations, special attention must be paid to calculation of dosage (ie, mg/kg).</p> <p>The patient’s chart shall contain documentation at the time of treatment that the patient’s level of consciousness and responsiveness, heart rate, blood pressure, respiratory rate,</p>

		<p>and oxygen saturation were monitored until the patient attained predetermined discharge criteria. A variety of sedation scoring systems are available and may aid this process. Adverse events and their treatment shall be documented.</p> <p><b>Documentation after treatment</b></p> <p>The time and condition of the child at discharge from the treatment area or facility shall be documented; this should include documentation that the child's level of consciousness and oxygen saturation in room air have returned to a state that is safe for discharge by recognized criteria. Patients receiving supplemental oxygen before the procedure should have a similar oxygen need after the procedure. Because some sedation medications are known to have a long half-life and may delay the patient's complete return to baseline of pose the risk of re-sedation some patients might benefit from a longer period of less-intense observation (eg, a step-down observation area) before discharge from medical supervision.<sup>133</sup> Several scales to evaluate recovery have been devised and validated. A recently described and simple evaluation tool may be the ability of the infant or child to remain awake for at least 20 minutes when placed in a quiet environment.</p>
<p><b>Conscious Sedation and General Anesthesia</b></p>	<p><b>Moderate Sedation</b></p>	
<p>The following records shall be</p>	<p>Documentation</p>	

<p>maintained:</p> <p>(2) General anesthesia and/or conscious sedation records, which shall include a time-oriented record with preoperative, multiple intraoperative pulse oximetry (every 5 minutes intraoperatively and every 15 minutes postoperatively for general anesthesia) and blood pressure and pulse readings, (both every 5 minutes intraoperatively for general anesthesia) drugs, amounts administered and time administered, length of the procedure, any complications of anesthesia or sedation and a statement of the patient's condition at time of discharge.(CCR 1043.3)</p>	<p>Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics, dosages and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record).</p> <ul style="list-style-type: none"> <li>• Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be recorded continually.</li> </ul>	
	<p><b>Deep Sedation or General Anesthesia</b></p>	
	<p>Documentation</p> <p>Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record)</p> <ul style="list-style-type: none"> <li>• Pulse oximetry and end-tidal CO2 measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.</li> </ul>	



Table 8.

Emergency drugs - California sedation laws compared to ADA and ADA-AAPD Guidelines

California - required emergency drugs	ADA Guidelines	AAP-AAPD Guidelines
Pediatric and Adult Oral Conscious Sedation (CCR 1044.5)	Minimal Sedation	All Levels of Sedation
<p>An emergency cart or kit shall be available and readily accessible and shall include the necessary and appropriate drugs and age- and size-appropriate equipment to resuscitate a nonbreathing and unconscious patient and provide continuous support while the patient is transported to a medical facility. There must be documentation that all emergency equipment and drugs are checked and maintained on a prudent and regularly scheduled basis. Emergency drugs of the following types shall be available:</p> <ol style="list-style-type: none"> <li>(1) Epinephrine</li> <li>(2) Bronchodilator</li> <li>(3) Appropriate drug antagonists</li> <li>(4) Antihistaminic</li> <li>(5) Anticholinergic</li> <li>(6) Anticonvulsant</li> <li>(7) Oxygen</li> <li>(8) Dextrose or other antihypoglycemic</li> </ol>	<p>The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.</p>	<p>Appendix C. Drugs That May Be Needed to Rescue a Sedated Patient</p> <p>Albuterol for inhalation            Ammonia spirits            Atropine            Diphenhydramine            Diazepam            Epinephrine (1:1000, 1:10 000)            Flumazenil            Glucose (25 percent or 50 percent)            Lidocaine (cardiac lidocaine, local infiltration)            Lorazepam            Methylprednisolone            Naloxone            Oxygen            Fosphenytoin            Racemic epinephrine            Rocuronium            Sodium bicarbonate            Succinylcholine            * The choice of emergency drugs may vary according to individual or procedural needs</p>
Conscious Sedation and General Anesthesia CCR 1043.3	Moderate Sedation	
<p>Drugs:            Emergency drugs of the following types shall be available:</p>	<ul style="list-style-type: none"> <li>• The qualified dentist is responsible for the sedative management,</li> </ul>	

<p>(1) Epinephrine  (2) Vasopressor (other than epinephrine)  (3) Bronchodilator  (4) Muscle relaxant (This is not required for conscious sedation.)  (5) Intravenous medication for treatment of cardiopulmonary arrest (This is not required for conscious sedation.)  (6) Appropriate drug antagonist  (7) Antihistaminic  (8) Anticholinergic  (9) Antiarrhythmic (This is not required for conscious sedation.)  (10) Coronary artery vasodilator  (11) Antihypertensive (This is not required for conscious sedation.)  (12) Anticonvulsant  (13) Oxygen  (14) 50% dextrose or other antihypoglycemic</p>	<p>adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.</p>	
	<p>Deep Sedation General Anesthesia</p>	
	<ul style="list-style-type: none"> <li>• The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.</li> </ul>	

## Table 9.

### State Mandated Office Inspection Requirements

1. California laws related to office inspections
2. Graphs summarizing requirements in 50 states

#### 1. California office inspection laws

##### General Anesthesia

1646.4. (a) Prior to the issuance or renewal of a permit for the use of general anesthesia, the board may, at its discretion, require an onsite inspection and evaluation of the licentiate and the facility, equipment, personnel, and procedures utilized by the licentiate. The permit of any dentist who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the dentist of the failure, unless within that time period the dentist has retaken and passed an onsite inspection and evaluation. Every dentist issued a permit under this article shall have an onsite inspection and evaluation at least once every five years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

(b) The board may contract with public or private organizations or individuals expert in dental outpatient general anesthesia to perform onsite inspections and evaluations. The board may not, however, delegate its authority to issue permits or to determine the persons or facilities to be inspected.

##### Conscious Sedation

1647.7. (a) Prior to the issuance or renewal of a permit to administer conscious sedation, the board may, at its discretion, require an onsite inspection and evaluation of the licentiate and the facility, equipment, personnel, and procedures utilized by the licentiate. The permit of any dentist who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the dentist of the failure unless, within that time period, the dentist has retaken and passed an onsite inspection and evaluation. Every dentist issued a permit under this article shall have an onsite inspection and evaluation at least once in every six years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

(b) An applicant who has successfully completed the course required by Section 1647.3 may be granted a one-year temporary permit by the board prior to the onsite inspection and evaluation. Failure to pass the inspection and evaluation shall result in the immediate and automatic termination of the temporary permit.

(c) The board may contract with public or private organizations or individuals expert in dental outpatient conscious sedation to perform onsite inspections and evaluations. The board may not,

however, delegate its authority to issue permits or to determine the persons or facilities to be inspected.

### **16 CCR § 1043.3**

#### **§ 1043.3. Onsite Inspections.**

Also see CCR 1043, 1043.2, 1043.4, 1043.5, 1043.6, 1043.7, 1043.8

All offices in which general anesthesia or conscious sedation is conducted under the terms of this article shall, unless otherwise indicated, meet the standards set forth below. In addition, an office may in the discretion of the board be required to undergo an onsite inspection. For the applicant who administers in both an outpatient setting and at an accredited facility, the onsite must be conducted in an outpatient setting. The evaluation of an office shall consist of three parts:

(a) Office Facilities and Equipment. The following office facilities and equipment shall be available and shall be maintained in good operating condition:

- (1) An operating theatre large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient.
- (2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation.
- (3) A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system which is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure.
- (4) Suction equipment which permits aspiration of the oral and pharyngeal cavities. A backup suction device which can operate at the time of general power failure must also be available.
- (5) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of allowing the administering of greater than 90% oxygen at a 10 liter/minute flow at least sixty minutes (650 liter "E" cylinder) to the patient under positive pressure, together with an adequate backup system which can operate at the time of general power failure.
- (6) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating theatre.
- (7) Ancillary equipment:
  - (A) Laryngoscope complete with adequate selection of blades and spare batteries and bulb. (This equipment is not required for conscious sedation.)
  - (B) Endotracheal tubes and appropriate connectors. (This equipment is not required for conscious sedation.)
  - (C) Emergency airway equipment (oral airways, laryngeal mask airways or combitubes, cricothyrotomy device).
  - (D) Tonsillar or pharyngeal type suction tip adaptable to all office outlets.
  - (E) Endotracheal tube forcep. (This equipment is not required for conscious sedation.)
  - (F) Sphygmomanometer and stethoscope.
  - (G) Electrocardioscope and defibrillator. (This equipment is not required for conscious sedation.)
  - (H) Adequate equipment for the establishment of an intravenous infusion.
  - (I) Precordial/pretracheal stethoscope.
  - (J) Pulse oximeter.
  - (K) Capnograph and temperature device. A capnograph and temperature measuring device are required for the intubated patient receiving general anesthesia. (This equipment is not required for conscious sedation.)

(b) Records. The following records shall be maintained:

- (1) Adequate medical history and physical evaluation records updated prior to each administration of general anesthesia or conscious sedation. Such records shall include, but are not limited to the recording of the age, sex, weight, physical status (American Society of Anesthesiologists Classification), medication use, any known or suspected medically compromising conditions, rationale for sedation of the patient, and visual examination of the airway, and for general anesthesia only, auscultation of the heart and lungs as medically required.
- (2) General Anesthesia and/or conscious sedation records, which shall include a time-oriented record with preoperative, multiple intraoperative, and postoperative pulse oximetry (every 5 minutes intraoperatively and every 15 minutes postoperatively for general anesthesia) and blood pressure and pulse readings, (both every 5 minutes intraoperatively for general anesthesia) drugs, amounts administered and time administered, length of the procedure, any complications of anesthesia or sedation and a statement of the patient's condition at time of discharge.
- (3) Written informed consent of the patient or if the patient is a minor, his or her parent or guardian.

(c) Drugs. Emergency drugs of the following types shall be available:

- (1) Epinephrine
- (2) Vasopressor (other than epinephrine)
- (3) Bronchodilator
- (4) Muscle relaxant (This is not required for conscious sedation.)
- (5) Intravenous medication for treatment of cardiopulmonary arrest (This is not required for conscious sedation.)
- (6) Appropriate drug antagonist
- (7) Antihistaminic
- (8) Anticholinergic

- (9) Antiarrhythmic (This is not required for conscious sedation.)
  - (10) Coronary artery vasodilator
  - (11) Antihypertensive (This is not required for conscious sedation.)
  - (12) Anticonvulsant
  - (13) Oxygen
  - (14) 50% dextrose or other antihypoglycemic
  - (d) Prior to an onsite inspection and evaluation, the dentist shall provide a complete list of his/her emergency medications to the evaluator.
- Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1646.2, 1646.3, 1647.3 and 1647.6, Business and Professions Code.

#### **HISTORY**

- 1. Amendment filed 4-1-91; operative 5-1-91 (Register 91, No. 18).
  - 2. Editorial correction of subsection (a)(4) (Register 95, No. 16).
  - 3. Amendment filed 2-27-2006; operative 3-29-2006 (Register 2006, No. 9).
- This database is current through 7/1/16 Register 2016, No. 27  
 16 CCR § 1043.3, 16 CA ADC § 1043.3

### **Oral Conscious Sedation**

#### **16 CCR § 1044.5**

See also CCR sections 1044, 1044.1, 1044.2, 1043.3, 1044.4

#### **§ 1044.5. Facility and Equipment Standards.**

A facility in which oral conscious sedation is administered to patients pursuant to this article shall meet the standards set forth below.

(a) Facility and Equipment.

- (1) An operatory large enough to adequately accommodate the patient and permit a team consisting of at least three individuals to freely move about the patient.
  - (2) A table or dental chair which permits the patient to be positioned so the attending team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation.
  - (3) A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system which is battery powered and of sufficient intensity to permit completion of any treatment which may be underway at the time of a general power failure.
  - (4) An appropriate functional suctioning device that permits aspiration of the oral and pharyngeal cavities. A backup suction device that can function at the time of general power failure must also be available.
  - (5) A positive-pressure oxygen delivery system capable of administering greater than 90% oxygen at a 10 liter/minute flow for at least sixty minutes (650 liter "E" cylinder), even in the event of a general power failure. All equipment must be age-appropriate and capable of accommodating the patients being seen at the permit-holder's office.
  - (6) Inhalation sedation equipment, if used in conjunction with oral sedation, must have the capacity for delivering 100%, and never less than 25%, oxygen concentration at a flow rate appropriate for an age appropriate patient's size, and have a fail-safe system. The equipment must be maintained and checked for accuracy at least annually.
- (b) Ancillary equipment, which must include the following, and be maintained in good operating condition:
- (1) Age-appropriate oral airways capable of accommodating patients of all sizes.
  - (2) An age-appropriate sphygmomanometer with cuffs of appropriate size for patients of all sizes.
  - (3) A precordial/pretracheal stethoscope.
  - (4) A pulse oximeter.
- (c) The following records shall be maintained:
- (1) An adequate medical history and physical evaluation, updated prior to each administration of oral conscious sedation. Such records shall include, but are not limited to, an assessment including at least visual examination of the airway, the age, sex, weight, physical status (American Society of Anesthesiologists Classification), and rationale for sedation of the minor patient as well as written informed consent of the patient or, as appropriate, parent or legal guardian of the patient.
  - (2) Oral conscious sedation records shall include baseline vital signs. If obtaining baseline vital signs is prevented by the patient's physical resistance or emotional condition, the reason or reasons must be documented. The records shall also include intermittent quantitative monitoring and recording of oxygen saturation, heart and respiratory rates, blood pressure as appropriate for specific techniques, the name, dose and time of administration of all drugs administered including local and inhalation anesthetics, the length of the procedure, any complications of oral sedation, and a statement of the patient's condition at the time of discharge.
  - (d) An emergency cart or kit shall be available and readily accessible and shall include the necessary and appropriate drugs and age- and size-appropriate equipment to resuscitate a nonbreathing and unconscious patient and provide continuous support while

the patient is transported to a medical facility. There must be documentation that all emergency equipment and drugs are checked and maintained on a prudent and regularly scheduled basis. Emergency drugs of the following types shall be available:

- (1) Epinephrine
- (2) Bronchodilator
- (3) Appropriate drug antagonists
- (4) Antihistaminic
- (5) Anticholinergic
- (6) Anticonvulsant
- (7) Oxygen
- (8) Dextrose or other antihypoglycemic

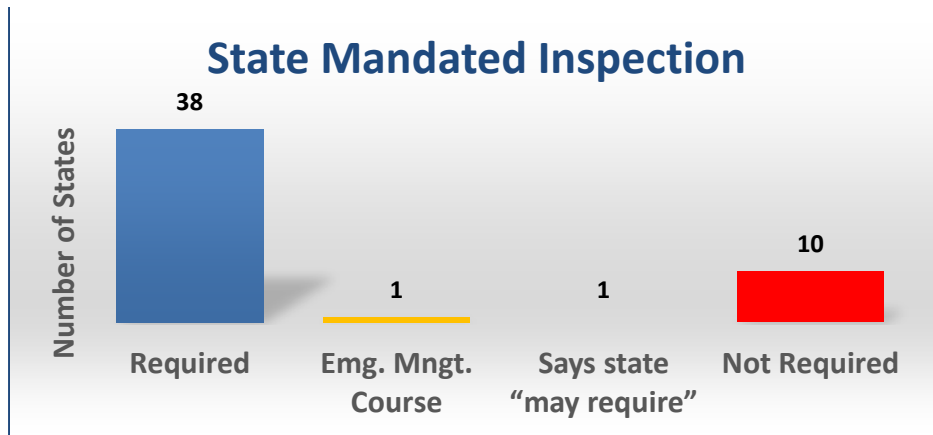
Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1647.10, 1647.16, 1647.22 and 1647.24, Business and Professions Code.

#### HISTORY

- 1. New section and new forms OCS-5 and OCS-3 filed 3-14-2000; operative 4-13-2000 (Register 2000, No. 11).
  - 2. Amendment of section and Note and repealer of printed forms (this action incorporates applicable forms within article 5.5 by reference) filed 12-13-2007; operative 12-13-2007 pursuant to Government Code section 11343.4 (Register 2007, No. 50).
- This database is current through 7/1/16 Register 2016, No. 27  
16 CCR § 1044.5, 16 CA ADC § 1044.5

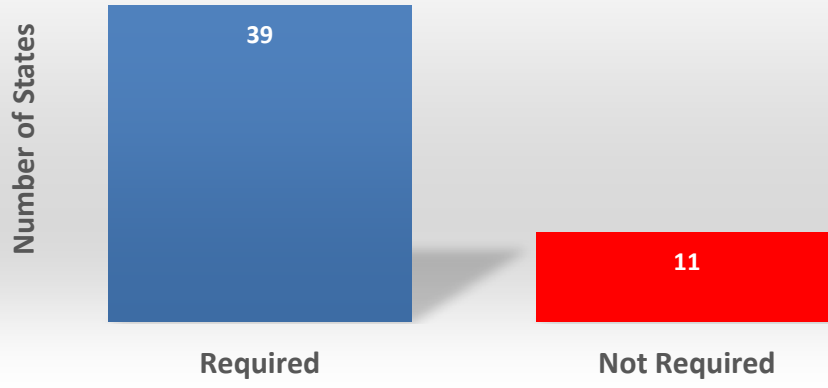
## 2. Summary of Requirements in 50 states

### General Anesthesia Permits



### Moderate (Parenteral) Sedation Permit

## State Mandated Inspection



## Table 10.

### Pediatric Sedation Laws for the 50 States – Summary

#### **Pediatric sedation requirements**

Individual states have taken different approaches to the regulation of pediatric sedation. Twenty five states, including California have special requirements for young patients. California requirements apply to patients age 13 or under. An increasing number of states have adopted pediatric sedation educational requirements, equipment requirements, and permits over the past 10 years. All states regulate moderate sedation and deep sedation/GA , regardless of route of administration.

Ten states (California, Colorado, Florida, Georgia, Kentucky, Louisiana, Missouri, Mississippi, North Carolina and Oklahoma ) require permits for sedating pediatric patients.

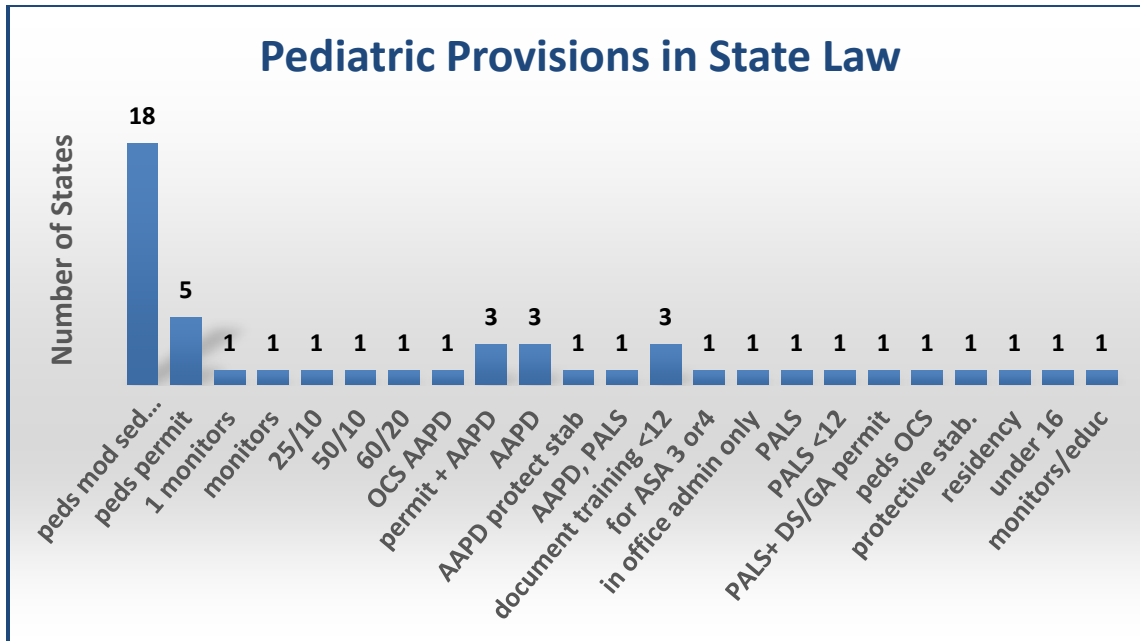
Sixteen states require specific training, some in addition to adult sedation training, to administer moderate/conscious sedation to pediatric patients.

Approximately twenty nine states have specific requirements for pediatric sedation administered by the oral route.

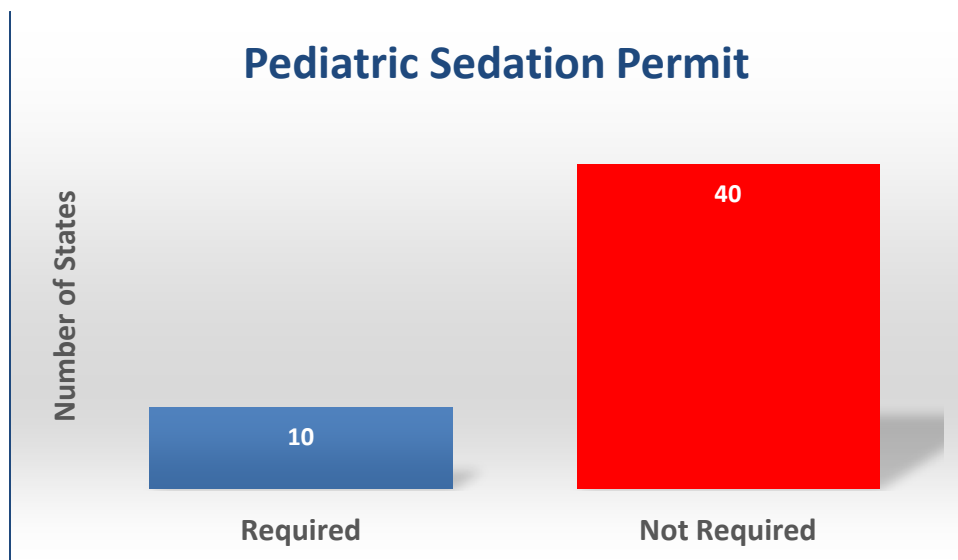
States differ in their definition of the pediatric patient. Several states define the pediatric patient as being under the age of 12 consistent with ADA Guidelines; however other states use 13, 14, 16 and 18 years of age. Most states, including California, specify that the practitioner must have appropriately sized equipment for pediatric patients. In some states ACLS certification is deemed sufficient for treating pediatric patients; Twenty states currently require PALS certification. California does not presently require certification in PALS.

Although ten states have adopted the AAP-AAPD Guidelines, these usually apply to minimal and moderate sedation. Most states do not have specific requirements for the administration of deep sedation/general anesthesia to children.





OCS = oral conscious sedation; 25/10 etc. = classroom hours/supervised cases; PALS= pediatric advanced life support course; all numbers are approximate.





# **WORKING DRAFT**

## STATISTICS RELATED TO PEDIATRIC SEDATION

In February 2016 Senator Jerry Hill, Chair of the Senate Committee on Business, Professions, and Economic Development was made aware of a tragedy in which an otherwise healthy child died after receiving general anesthesia at a dentist's office. He notified the Dental Board of California (Board) of his concern about the rise in the use of anesthesia for young patients and asked the Board to investigate whether California's present laws, regulations, and policies are sufficient to protect the public. In doing the research, Senator Hill asked the Board to review all incident reports related to pediatric anesthesia in California for the past five years.

For the purpose of this review, "incident report" is defined as the notification the Board received from a licensee in accordance with reporting requirements of Business & Professions Code (BPC) Section 1680(z) relating to (1) the death of a patient during the performance of any dental or dental hygiene procedure; (2) the discovery of the death of a patient whose death is related to a dental or dental hygiene procedure performed by the dentist; and (3) the removal to a hospital or emergency center for medical treatment for a period exceeding 24 hours of any patient to whom oral conscious sedation, conscious sedation, or general anesthesia was administered, or any patient as a result of dental or dental hygiene treatment. While some notifications provide specific details of the incident, other notifications have minimal information. The regulation does not specify what information is required to be included in the notification to the Board.

This report will therefore reflect statistics related to incident reports of death and hospitalizations related to use of local anesthetic, oral conscious sedation, conscious sedation, general anesthesia, and "other" incidents NOT related to sedation for pediatric patients reported over a six year period, January 1, 2010 – December 31, 2015. For the purposes of this report, the age of a pediatric patient is defined as 21 years and younger.

In order to identify instances of pediatric hospitalizations and deaths reported to the Board, statistical reports from the Consumer Affairs System (CAS) database were pulled for cases tracked with specific violation codes related to the Board's reporting requirements under BPC Section 1680(z). Reports pulled from the database were based on coding entered by complaint intake staff upon initial receipt of the notification and/or complaint.

Eight Board staff, including two Dental Consultants, and four investigative staff, reviewed all available incident reports, investigative files, and cases identified and recorded in the Board's database relating to death or hospitalization cases. As there is no mechanism to sort data by age, therefore approximately 325 records and investigative files were reviewed in order to determine the number of pediatric hospitalizations and deaths reported or investigated by the Board in relation to dental treatment.

A portion of the cases identified in the database were not able to be reviewed as the files were not able to be located, or were purged pursuant to the Board's records retention schedule. The Board's records retention schedule indicates that closed files (that did not result in disciplinary action) shall remain on record as follows:

## WORKING DRAFT – STATISTICS RELATED TO PEDIATRIC SEDATION

Complaints closed without merit	1 year
Complaints closed with merit	5 years
Investigations closed with no violation	1 year
Investigations closed with insufficient evidence	3 years

### **NOTIFICATION OF PEDIATRIC DEATHS**

Review of the incident reports combined with additional information obtained during the course of the Board's investigations revealed that during the six year period identified as January 1, 2010 through December 31, 2015, the Board received notice of nine pediatric deaths, four of which involved general anesthesia. A summary of the findings by year follows:

#### **2010**

Review of records indicated that in 2010, the Board received no notification of pediatric deaths.

#### **2011**

In 2011, three cases were received. Board review indicated the following:

- Investigation into the treatment of a three year old child under conscious sedation resulted in a referral to the Office of the Attorney General and an accusation was filed; the accusation was subsequently withdrawn.

The patient was treated in a dental office for restorations of 20 teeth under conscious sedation on December 9, 2011. During the procedure the patient was awake and crying; additional sedation was administered by the provider. The patient was discharged to parent at 11:30 a.m., and did not wake after the procedure. 911 was called at 3:00 p.m.; the patient was pronounced dead the following evening.

- Investigation into the treatment of a four year old patient under general anesthesia on November 11, 2011, indicated insufficient evidence to proceed with disciplinary action.

The patient was treated under general anesthesia, administered by a medical anesthesiologist at a hospital, for dental caries and gingivitis. The patient had a complex cardiac history and treatment was rendered at a large children's hospital. The dental procedures were completed uneventfully, and the patient was extubated. In the recovery room the patient experienced cardiac arrests, and expired after 45 minutes of resuscitation efforts. A coroner's report, and review by six coroner bureau staff concluded it was a natural death.

## WORKING DRAFT – STATISTICS RELATED TO PEDIATRIC SEDATION

- Investigation related to the treatment of a nine year old child under local anesthetic (xylocaine) on December 5, 2011, indicated no violation.

On December 5, 2011, a severely compromised nine year old patient was transferred by paramedics from a sub-acute care facility for extraction of six primary teeth under local anesthetic, at a university dental school. The patient's health history was significant for spinal muscular atrophy type 1, global delay, reactive airway disease, asthma, osteopenia, chronic respiratory failure, anemia, aspiration pneumonia, constipation, failure to thrive, g-tube, gastric hypo motility, gerd, osteoporosis, quadriplegic, bed ridden, and nonverbal.

Treatment was performed and at the end of the procedure the patient's vitals were close to baseline. The paramedic team declined the offer of the dental school's emergency medical assistance and the patient was dismissed under the care of the paramedic team. The patient was then transported by the paramedic team to the university medical center emergency room because his blood pressure started to drop. The patient arrived at the emergency room in full arrest; cause of death is listed as cardiopulmonary arrest.

### **2012**

Review of records indicated that in 2012 the Board received no notification of pediatric deaths.

### **2013**

The Board received four notifications related to pediatric death in the year 2013. Of the four notifications received, three notifications were related to the treatment of a single patient by multiple providers, thereby reflecting only two incidents for this year.

- Investigation was initiated upon receipt of notification related to the treatment of an 11 year old child on May 22, 2013. The investigation found no violation occurred related to the treatment.

The patient had a history of mucopolysaccharidosis Type VII, and behavioral issues, and required treatment of decay under general anesthesia. Treatment of tooth #3 was initiated, at a university health clinic for children with anesthesia administered by an anesthesiologist. During the treatment, irregular cardiac patterns were detected, and treatment was halted. The medical team attempted to stabilize the patient without success.

- Investigation was initiated upon receipt of notification related to the death of a 19 year old patient. Three investigations were initiated as three dental providers were involved in the treatment. Two investigations resulted in referral to the Office of the Attorney General, and one investigation resulted in a closure with no violation.

Provider #1 saw patient on January 14, 2014, February 1, 2013, February 28, 2013, and March 6, 2013, for issues related to pain. Provider #1 placed a MODLB onlay on tooth #30, on February 1, 2013. Patient was seen by provider #1 an additional two times; February 28, 2013, and March 6, 2013 (#30 bite adjustment), for continued issues with pain. On March

## WORKING DRAFT – STATISTICS RELATED TO PEDIATRIC SEDATION

16, 2013, patient's mother called as patient continued to have pain, and spoke to provider #1 who felt patient had discomfort from grinding and recommended a night guard.

A second opinion was requested from provider #2, who attempted to fix the crown at #30 two times (March 20, 2013, March 22, 2013) without success. Provider #2 referred patient to provider #3, an endodontist on March 22, 2013, who on the same day performed a partial root canal treatment on tooth #30, and prescribed antibiotics, pain pills, and made a follow up appointment.

The mother, who accompanied the patient to the appointment, left her in the car while filling the prescription at a pharmacy. When the mother returned to the car, the patient was unresponsive. 911 was called, the patient passed four days later; the cause of death is listed as sepsis, clinical dental infection with multiple dental procedures, clinical.

### **2014**

Review of records indicated that in 2014 the Board received no notification of pediatric deaths.

### **2015**

The Board received four notifications related to pediatric death in the year 2015.

- Investigation was conducted upon receipt of notification related to treatment rendered to a 17 year old patient under general anesthesia on April 1, 2015. The investigation indicated insufficient evidence to proceed with disciplinary action.

The 17 year old patient had history significant for cerebral palsy, seizure disorder, 1P36 chromosomal deletion syndrome, chronic constipation, and thrombocytopenia secondary to valproic acid. Medical consultations were obtained from the patient's neurologist, hematologist, and GI doctor prior to treatment under general anesthesia for decay, prophylaxis, x-rays, and dental pain. Treatment was performed at a pediatric children's hospital by two dental providers. X-rays were taken, the prophylaxis was performed, and one primary over retained tooth and four permanent teeth were extracted, without issue.

Patient was transferred to post anesthesia care unit, but was not able to be removed from the respirator. Five days later the patient suffered complications involving pneumonia and the parents asked the patient be removed from life support.

- Investigation was conducted upon notification of the death of a six year old patient, who was placed under general anesthesia for dental treatment. The investigation resulted in referral to the Office of the Attorney General; outcome is pending.

The six year old patient presented to a dental office for the extraction of a mesiodens in the area of #9 under general anesthesia on March 13, 2015. Following the administration of a local anesthetic, the provider reported not being able to hear the patient breathing. Oxygen/mask bag was applied, and 911 was called; the oxygen/mask bag was unsuccessful.

## WORKING DRAFT – STATISTICS RELATED TO PEDIATRIC SEDATION

While waiting for EMS, the provider unsuccessfully attempted to intubate patient; the provider continued with mask/bag ventilation until EMT arrived. After two days of treatment, MD ordered compassionate withdrawal of care. Cause of death listed as hypoxic encephalopathy due to cardiac arrest.

- Investigation was conducted upon notification of the death of a three year old patient after treatment in a pediatric dental office. The investigation resulted in the referral to the Office of the Attorney General; outcome is pending.

The three year old patient presented to a pediatric dental office for restorative treatment in all four quadrants under oral sedation, with a papoose board on February 25, 2015. The patient was in treatment for four hours and was in recovery for two hours when he became tachycardic and his oxygen saturation decreased. Patient was given oxygen and was monitored, about one hour later (3 hours after treatment), 911 was called. Patient was transported to the hospital, and expired 4 days later; cause of death listed a malignant hyperthermia, with cerebral edema and hypoglycemia as underlying causes.

- Investigation related to the treatment of a three year old child under local anesthetic (lidocaine, septocaine, and nitrous oxide) on July 30, 2015, is ongoing.

On July 30, 2015, the three year old patient was undergoing dental treatment under nitrous oxide and local anesthetic, and became non-responsive. CPR was initiated, and paramedics were called. Patient was transported to the hospital and passed on August 1, 2015. The cause of death was not known at the time the report was submitted to the Board.

## WORKING DRAFT – STATISTICS RELATED TO PEDIATRIC SEDATION

A simplified summary of the Board’s findings related to pediatric deaths for the years 2010 through 2015 is as follows.

<b>Year of occurrence</b>	<b>Age</b>	<b>Type(s) of anesthesia or anesthetic administered</b>	<b>Treatment/Setting</b>	<b>Discipline</b>
2010	NO DEATHS REPORTED			
2011	3	Conscious sedation	Dental office	Accusation withdrawn 8/21/15
2011	4	General anesthesia	Hospital with Anesthesiologist	Closed insufficient evidence
2011	9	Local anesthetic	Sub-acute care facility/Hospital	No violation
2012	NO DEATHS REPORTED			
2013	11	General anesthesia	Hospital with Anesthesiologist	No violation
2013	19	Local anesthetic	Dental offices	2 Accusations filed 12/28/15 (and one finding of no violation)
2014	NO DEATHS REPORTED			
2015	3	Pediatric oral sedation	Pediatric dental office	Accusation 9/30/15
2015	3	Local anesthetic and nitrous oxide	Hospital	Pending
2015	6	General anesthesia	Dental office	Accusation filed 2/24/2016
2015	17	General anesthesia	Hospital	No violation



WORKING DRAFT – STATISTICS RELATED TO PEDIATRIC SEDATION

**NOTIFICATION OF PEDIATRIC HOSPITALIZATIONS**

Board staff conducted additional review of hospitalizations of pediatric patients from January 1, 2010, through December 31, 2015. The following chart summarizes the number of instances; and breaks down incidents by the year of occurrence, the patient’s age, and the type of sedation used, if applicable.

\*Cases reflected in the below summary account for separate incidents and patients.

Summary of Pediatric Hospitalization by Year and Patient Age 2010-2015						
Year	Age	Conscious Sedation	General Anesthesia	Local Anesthetic	Unknown	Grand Total
2010	3		1			1
	18			1		1
2010 Total			1	1		2
2011	17				1	1
2011 Total					1	1
2012	3		1			1
	6*		1	1		2
	14		1			1
	18*		1	1		2
2012 Total			4	2		6
2013	1.5			1		1
	1.7		1			1
	3*	1	1			2
	4				1	1
	15		1			1
	17*	2	1	1		4
	18		1			1
	20	1				1
unknown					1	1
2013 Total		4	5	2	2	13
2014	2.5		1			1
	3*	1	1			2
	4*	1	2	2		5
	5		1			1
	6*	1	1			2
	7			1		1
	14		1			1
	17		1			1
19				1	1	
2014 Total		3	8	4		15
2015	2*	1	2			3
	3.5	1				1
	8		1			1
	14		1			1
	15		1			1
21		1			1	
2015 Total		2	6			8
Grand Total		9	24	9	3	45

## WORKING DRAFT – STATISTICS RELATED TO PEDIATRIC SEDATION

A more detailed account of these instances is available for review; refer to the attached *Summary Report of Pediatric Hospitalizations* for additional details including final outcome. Of note, in some instances multiple providers rendered treatment to a single patient. As such, multiple reports exist for a single instance; this is reflected in the *Summary Report of Pediatric Hospitalizations*.

For the purpose of this inquiry, the Board has examined all identified notifications and investigations of pediatric deaths and hospitalizations. During the course of an investigation, the Board gathers information and evidence, and conducts investigations with the intent to determine if dental treatment was rendered within the community standard of care.

Any notifications of potential violations are initially received and reviewed by the Complaint and Compliance Unit (CCU). CCU staff initially review and enter the complaint in the database. The matter is then referred to an analyst within the CCU to determine priority, gather records, and prepare for review by an in-house dental consultant. The in-house dental consultant determines at a general level, if the treatment was within the community standard of care. If the in-house consultant finds a deviation from the community standard of care, the matter is referred to investigation.

Of note, each case has different factors and components that are used to determine priority. Reports of patient death are immediately referred to investigation, and are handled and investigated as a priority matter.

Upon initial receipt by investigative staff, the case is reviewed and evaluated for potential Dental Practice Act (DPA) and community standard of care violations. Matters are reviewed by investigative staff upon first receipt for prioritization. Upon investigation of each individual case, evidence is obtained, records are gathered, and interviews are conducted.

The investigative evidence gathered is then forwarded to a subject matter expert (SME) in the area of treatment, for review and determination of violation(s) of the community standard of care and the DPA. The SME prepares a report of his or her findings, and based on the findings, the Board will proceed accordingly; i.e., referral to the Office of the Attorney General, case closure; with no violation or insufficient evidence, a citation and fine, etc.

Cases are referred to the Office of the Attorney General for consideration of disciplinary action, including revocation, suspension, or probation. Matters closed with no violation are a result of a finding that the treatment rendered did not deviate from the community standard of care. A case closed due to insufficient evidence indicates that the available evidence did not support that charges could be successfully filed by the Office of the Attorney General.

The Board receives a broad range of complaints and the information gathered in response to a complaint is specific to each case, and varies widely from investigation to investigation. The information obtained during the course of an investigation is germane to the specific case and the associated allegations. The data provided in this report should be interpreted with caution

## WORKING DRAFT – STATISTICS RELATED TO PEDIATRIC SEDATION

because board information systems are designed primarily for tracking, management, and reporting of enforcement activity. These systems were not designed for the systematic collection and analysis of outcomes research data.

DRAFT



Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
1	2010	3	unknown	F	X-ray, Prophy, Fillings, RCT, Crown	X-ray, Prophy, Filling	Surgery Center	EKG, BP, Steth, O2 Sat, Pulse OX, CO2	GA	O2, Ultra, Ketamine, Demerol, Decadron, Versed, Propofol	No Violation	Patient suffered airway obstruction, Paramedics transported to hospital. Patient survived. - same as incident #2
2	2010	3	unknown	F	X-ray, Prophy, Fillings, RCT, Crown	X-ray, Prophy, Filling	Surgery Center	EKG, BP, Steth, O2 Sat, Pulse OX, CO2	GA	O2, Ultra, Ketamine, Demerol, Decadron, Versed, Propofol	No Violation	Patient suffered airway obstruction, Paramedics transported to hospital. Patient survived. - same as incident #1
3	2010	18		f	cleaning and fillings	exam, x-ray, cleanings	dental office	n/a	Local	1.8ml of 3% carbocaine, one carpule Benadryl	referred to discipline	patient reported reactions to prior anesthetic injections, was given carbocaine, developed rash and felt her throat was closing. Was given benadryl injection and advised to report to hospital. Observed at hospital that symptoms had resolved and released home same day
4	2011	17	unknown	M	Unknown	Unknown	University Dental Clinic	Unknown	Unknown	unknown	No Violation	Patient treated for dentistry at University Dental Clinic. Special Needs Patient was hospitalized a day later for Pneumonia like symptoms.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
5	2012	3	35 lbs.	F	Loose front teeth / prior accident	Radiographic procedures	Surgery Center	SaO2 FIO2 EKG	GA	Albuterol 2.5mg / Nebulizer 3ml /	insufficient evidence	3 yr. old female received GA by an anesthesiologist - not the dentist. During sedation developed a nose bleed and was transported to the hospital. Fault was found with the anesthesiologist, not the treating dentist.
6	2012	6		m	infection at teeth #S and #T	#S and #T extracted	dental office	n/a	Local	lidocaine, nitrous oxide	no violation	patient presented with facial cellulites, swollen tonsils, teeth #S & #T were infected. Teeth were extracted with agreement that parents were to immediately report to hospital after extractions. Pt report to ER and was observed and treated until infection was cleared

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
7	2012	6	23.3 kg	m	caries treatment	pulpotomies, SSC, extractions	dental surgery center	auto NIBP, EKG, SpO2, ETCO2, Temp	GA	140 mg propofol, 150 mcg alfenta, 30 mg lasix, 40 mg hydrocortisone, 20 mg succinylcholine, 4 mg dexamethasone, 150 mcg propolo, .4 mg epinephrine	insufficient evidence	after procedure patient developed rash on cheeks, and oxygen began to desaturate, transferred to hospital & held for 48 hours, released home -same as incident #8
8	2012	6	50 lb	M	dental caries, acute situational anxiety	treatment of caries, stainless steel crowns, pulpotomies, extractions	dental surgery center	auto NIBP, EKG, SpO2, ETCO2, Temp	GA	22g IV, IV fluid 5% dextrose, open airway technique w/100% oxygen @3 liters & CO2 line, anesthetic consisting of propofol infusion & intermittent boluses, 150 mcg alfentanil	insufficient evidence	after procedure patient developed rash on cheeks, and oxygen began to desaturate, transferred to hospital & held for 48 hours, released home -same as incident #7

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
9	2012	14		M	dental treatment under anesthesia patient w/cerebral palsy, mental retardation, and seizure disorder	n/a	surgery center	O2, EKG, E + CO2	GA	Midazolam PO 10, Ketamine IM 250, Dexamethasone 10, NS 950,	no violation	Treatment cancelled on 5/18/12 after difficulty in ventilating the patient after introduction of general anesthesia. Pt recovered and managed in surgery center w/o complications. Discharged; however, had nausea and vomiting. Mother took patient to ER where he was diagnosed w/pneumonia and kept for observation until discharge on 5/20/12 - same as incident #10



Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
10	2012	14		M	dental treatment under anesthesia patient w/cerebral palsy, mental retardation, and seizure disorder	n/a	surgery center	O2, EKG, E + CO2	GA	Midazolam PO 10, Ketamine IM 250, Dexamethasone 10, NS 950,	no violation	Treatment cancelled on 5/18/12 after difficulty in ventilating the patient after introduction of general anesthesia. Pt recovered and managed in surgery center w/o complications. Discharged; however, had nausea and vomiting. Mother took patient to ER where he was diagnosed w/pneumonia and kept for observation until discharge on 5/20/12 - same as incident #9

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
11	2012	18	210lbs	F	Dental Anesthesia	Dental Anesthesia	Dental Office	Temp, Pulse OX, BP, O2 Saturation	GA	Fentanyl, Ampicillin	No Violation	Patient transferred to hospital by parents, 1 day after surgery for facial swelling following wisdom tooth extraction.
12	2012	18		f	wisdom teeth extractions	surgical extraction of wisdom teeth	dental office	n/a	Local	nitrous oxide, 1.7 cc xylo 2% epi, 1:100k x 6 carpules, 1.7 cc articaine hcl 4% with epi 1:100 k x 1 carpule, inject 10 mg dexamethasone	insufficient evidence	patient had pain and severe swelling and reported to hospital for treatment, patient was diagnosed w/acute spepsis and severe submandibular/neck swelling w/cellulitis, without evidence of abscess. Patient was discharged after symptoms improved, four days later

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
13	2013	1.5	24 lb	m	unrestorable gross caries teeth #D-G, N-Q; w/swelling progressed to facial cellulites	ER Extraction of teeth #D-G, N-Q w/patient to report to ER post extraction for IV antibiotic	dental clinic	n/a	Local	.5 carp 2% lidocaine w/1:100,000 epinephrine in papoose	No Violation	DDS advised prior to treatment, that post treatment patient would be required to report to ER for IV antibiotics. Pt reported and was admitted as advised by DDS. Hospitalization was a scheduled event.
14	2013	1.7	28 lb.	f	rampant decay of maxillary teeth	caries treatment	surgery center	auto bp, ekg, pulse ox, O2 monitor, Temp	GA	glyco .1 mg, ketamine 50 mg, demerol 15 mg, versed .5 mg, propofol 150 mg	no violation	approx 20 mins after tx, patient began having trouble breathing, patient was transported via EMS to ER and was it determined patient had previously undiagnosed reactive airway.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
15	2013	3	21 kg	m	caries treatment	caries treatment	dental office		CS	60mg midazolam; 30mg hydroxyzine hydrochloride	insufficient evidence (subject deceased)	patient presented for caries, mother informed subject patient had asthma exacerbation the night before. Subject decided to proceed with sedation & procedure. After procedure patient had difficulty breathing and was quite sleepy. Pt was treated for status asthmaticus and benzodiazepine overdose.
16	2013	3	47 lb	f	treatment of 18 teeth w/pulpotomies and SSC	pulpotomies and SSCs	dental surgery center	pulse oximeter, EKG, blood pressure cuff temperature probes	GA		closed no violation	Patient's lips began swelling during treatment, patient was stabilized and treatment completed. Patient transported to hospital discharged following day with diagnosis of latex allergy.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
17	2013	4	unknown	F	Unknown	Unknown	Dental Office	Unknown	Unknown	Unknown	Insufficient Evidence	Complaint stated that daughter fell out of dental chair, while sedated, cutting her head. Parents took their child to ER for Derma Bond Bandage. Case closed because mother never responded to Board's request.
18	2013	15	114Lbs	M	4 3rd molar Ext.	4 3rd molar Ext.	Dental Office	NIBP, EKG, Pulse Oximeter	GA	6 Carpules of 2% Lidocaine, Propofol, Ketamine, Versed, Robintl and Fentanyl	No Violation	Father of patient complained that after his son was discharged in the parking lot of dental office his son was suffering from respiratory distress and had to call 911. Patient was brought into office and DDS was able examine patient who was with in normal limits. Patient was transported to hospital. Patient appeared to have a panic attack according to Paramedics.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
19	2013	17		F	multiple interproximal caries, significant decay @ #3, 19, and 30; #19 RCT, decay @ #2-#6, #12-#15, #18-#20, #22, #28-#30	treatment of caries; with some unfinished restorations	dental office	SpO2, temp, pulse, blood pressure	CS	25 mg versed, 90 mg fentanyl, 8.75 mg morphine, 3 1/2 carpule Citanest 4%, 2 1/2 carpule septocaine 4%, 6 carpule xylocaine 2%, 8mg decadron IV, zofran 8mg, 3 doses of 0.1mg epinephrine	referred to discipline - subject deceased	patient reported for treatment under IV sedation - sedated for approximately 8 hours. Pt's blood pressure and oxygen levels dropped and patient began vomiting. EMS was called - patient presented to ER w/acute respiratory distress, and hypotension, Pt was determined to have had a heart attack, aspirated blood and vomit. Pt remained in ICU on respirator for three days, and hospitalized for one week.
20	2013	17	195	F	Restorative work 17 teeth	Most of 17 tooth restorative work completed	Private practice	Unknown	CS	Fentanyl, Morphine, Versed Decadroa	referred to discipline	17 yr. old went in to have 17 teeth fixed and towards end of CS started to vomit. Transported to ER was in ICU 4 days. DR. stated she was over sedated.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
21	2013	17	140 lbs.	M	Removal of wisdom teeth	Removed wisdom teeth	Private practice	Pulse Oximeter / NIBP / ECG	GA	Propofol, Dackadrome	insufficient evidence - rejected by AGO	Patient under went GA with no issues. However was aggressive when waking up from GA. Had to be restrained and transported to ER. Later claimed Posttraumatic stress disorder due to treatment. Same as incident #22.
22	2013	17	140 lbs.	M	Removal of wisdom teeth	Removed wisdom teeth	Private practice	Pulse Oximeter / NIBP / ECG	GA	Propofol, Dackadrome	insufficient evidence - rejected by AGO	Patient under went GA with no issues. However was aggressive when waking up from GA. Had to be restrained and transported to ER. Later claimed Posttraumatic stress disorder due to treatment. Same as incident #21.
23	2013	17		m	rct #5	rct #5	dental office	n/a	Local	lidocaine 2% w/1:100k epinephrine	insufficient evidence	during RCT patient began having swelling on right side of face, patient transported to the ER. Pt was observed and released the next day.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
24	2013	18	160lbs	F	Oral Surgery	Oral Surgery	Loma Linda Dental School	EKG, Pulse OX, BP, CO2, Pre-Cordial Monitor,	GA	Propofol, Versed, Fentanyl, Toradol, Phrnly-Epherine,	No Violation	During recovery the patient transported to hospital after oral surgery and General Anesthesia. Patient was diagnosed with Cardiac irregularity. Patient was discharged in 2 days.
25	2013	20	192lbs	F	Extractions	Extractions	Dental Office	B.P., O2, EkG	CS	5mg Versed, 25mg Ketamine, 100mg Propfol, 8 Dacdron, 6 Carpules of Lidocaine, 10 mg. Diazepam	Insufficient Evidence	Patient presented on 8/6/13 for extraction of wisdom teeth. Patient had health history for seizure disorder and stroke in utero. After uneventful extraction of teeth #16 and #17, patient began having uncontrollable convulsive movements. Due to health history and uncontrolled convulsions, EMS was contacted and patient was taken to hospital. Events were diagnosed as a Psychogenic origin.



Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
26	2013	unknown		F	Facial Cellulites, Extraction of tooth #A	Extraction of tooth #A	dental office	n/a	Unknown	Unknown	No Violation	Subject saw patient as emergency referral upon release from hospital for treatment of facial cellulites, for extraction of tooth #A on 4/16/13. Subject advised mother to take patient to hospital if swelling got worse. At 4:00 p.m. the same day, patient was taken to hospital and admitted for infection. Doctors determined patient had abscess which lead to sinusitis, and progressed to facial cellulites. Patient discharged on 04/19/13.
27	2014	2.5	unknown	F	Unknown	Unknown	Unknown	Unknown	GA	Unknown	Pending	Patient treated under GA by Anesthesiologist. Patient suffered Bronco spasm. The patient was treated and released. Case is still under investigation.

Summary Report of Pediatric Hospitalization  
Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
28	2014	3	35	m	rampant decay on 17 teeth	caries treatment	dental office	SpO2, ECG, Temperature, EtCO2	GA	illegible	no violation	patient reported to ER two days after treatment for facial swelling, patient was admitted and received IV antibiotics, was discharged four days later in stable condition - same as incident #29
29	2014	3	35	m	rampant decay on 17 teeth	caries treatment performed by pediatric dentist	dental office	SpO2, ECG, Temperature, EtCO2	GA	illegible	no violation	patient reported to ER two days after treatment for facial swelling, patient was admitted and received IV antibiotics, was discharged four days later in stable condition - same as incident #28
30	2014	3	43.5lbs	M	4 crowns, X-rays	4 Crowns and Restorations	Dental Office	Not Noted	CS	Lidocaine w/Epi, Nitrous Oxide, Chloral hydrate	referred to discipline	Pedio patient treated. Later the patient was running a high fever upon hospitalization; MD noted that patient's lung collapsed.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
31	2014	4		f	restorations in lower right quadrant	n/a	dental office	n/a	local	nitrous oxide, topical anesthetic, local anesthetic	no violation	needle separated from hub during administration of local anesthetic, patient was referred to oral surgeon at hospital. Needle was surgically removed in outpatient procedure.
32	2014	4	unknown	F	5 fillings	5 Fillings	Surgery Center	Unknown	GA	Unknown	Pending Case	4 year old patient suffered a reaction to anesthesia agent. Patient was transported to hospital. Case is still pending. Same as incident #33
33	2014	4	unknown	F	5 Fillings	5 Fillings	Surgery Center	Unknown	GA	Ketamine	Pending Case	4 year old patient suffered a reaction to anesthesia agent. Patient was transported to hospital. Case is still pending. Same as incident #32

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
34	2014	4	16.3 kg	m	dental rehabilitation	dental rehabilitation	dental surgery center	auto NIBP, EKG, SpO2, ETCO2, Temp	GA	190 mg propofol, 50 mcg fentanyl, dexamethasone 4 mg	pending	patient underwent treatment under GA w/o complications. In recovery room patient displayed abdominal distension. Pt transferred via ambulance and successfully underwent surgery. Diagnosis from MD patient experienced peritonitis due to spontaneous gastric rupture with unknown etiology.
35	2014	4	34lbs	M	9 fillings	9 fillings	Dental Office	Unknown	CS	Propofol, Ketamine, Glycopyrolate	Pending	4 year old patient under CS suffered bronchospasm. Patient was transferred to hospital. Patient discharged a day later.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
36	2014	4	unknown	M	Fillings	Fillings	Dental Office	N/A	Local	2 carpules lidocaine 2%	No Violation	Dental treatment performed on patient who had an infection; infection resulted in patient requiring treatment at hospital. Mother took patient to ER on 07/02/14 and was treated and released; Mother took patient to ER on 07/03/14, and was treated and kept until 07/06/14 and discharged. Patient was diagnosed with cellulitis.
37	2014	5	45lbs	F	Restorative	Restorative	Surgery Center	Pulse Oximeter, EKG, BP, Precordial	GA	Albuterol, Epinephrine, Atropine, Decadron, Midazolam, Fentanyl, Ketamine	No Violation	Patient transported to hospital when O2 Saturation Level fell below 90%. Patient stayed in the hospital overnight for stabilization and the then discharged.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
38	2014	6	53	m	complete oral dental restoration	extractions, caries treatment	dental surgery center	SpO2, ECG, Temperature, EtCO2, FiO2	GA	glyco 1.2, ketamine 60, versed 1, propofol 100, fentanyl 500, (grams/micrograms not clearly documented)	no violation	Autistic patient with history of heart murmur, provider noted EKG showed possible second degree heart block mobitz type 1. Anesthesiologist recommended follow up by pediatric cardiologist. Treatment completed w/out incident. Patient was able to receive treatment for previously undiagnosed heart condition.
39	2014	6	unknown	F	Dental TX under sedation	Dental TX Under Sedation	Dental Office	O2 Sat, Pulse OX. BP	CS	Nitrous, Versed, Visteril, 1 Carpule 2% Lidocaine, w/epi	Pending	Patient was given treatment (5 fillings and extractions) under CS and Nitrous. Patient was released at 11 am taken to ER by mother at 12:00pm. Patient was very drowsy . Patient was discharged the same day at 6:26 pm.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
40	2014	7		f	pulpotomy #K, #L, and #R, and extraction of #S	pulpotomies and extraction	dental office	n/a	Local	local anesthetic	no violation	patient suffered superficial cut on tongue during dental treatment, and was taken to ER by parent for observation - patient was released and antibiotics were prescribed
41	2014	14	110lbs	M	Multiple Ext.	None	Dental Office	BP, EKG, Pre-Cordial, Pulse Ox., CO2	GA	Fentanyl, Propofol, Versed, Decadron, Zofran, benardryl, Epi, Lidocaine, Marcaine	No Violation	14 year old Patient, suffered reaction to anesthesia. DDS reversed meds and patient was transported to hospital. Patient was discharged 1 day later.
42	2014	17	Unknown	F	3rd Molar Ext.	3rd Molar Ext.	Surgery Center	BP, Pulse Ox. Carprography, EKG, Precord	GA	Unknown	Pending	Patient experienced 2 syncopal episodes at home. The patient was transferred to hospital and was discharged the next day.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
43	2014	19	165lbs	M	Ext.	Ext.	Dental Office	None	Local	Lidocaine	insufficient evidence	Patient was seen for surgical extractions and rapid palatal expansion treatment. Subject did not extract all indicated teeth, and patient had to return for additional extraction treatment. Patient additionally had swelling and abscess at extraction site which required treatment in emergency room.
44	2015	2	12.7 kg	m	caries treatment	restorations and crowns preparations	dental surgery center	EKG, auto NIBP, SpO2, ETCO2, Temp	GA	200 mcg propofol, 30 mg demerol, 500 mcg alfentanil,	pending	patient presented for dental treatment under anesthesia. During procedure patient began to have bradycardia with accompanying hypoxia. Pt stabilized and transported to ER and remained overnight for observation - same as incident #45



Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
45	2015	2	12.7 kg	m	caries treatment	restorations and crowns preparations	dental surgery center	EKG, auto NIBP, SpO2, ETCO2, Temp	GA	200 mcg propofol, 30 mg demerol, 500 mcg alfentanil,	pending	patient presented for dental treatment under anesthesia. During procedure patient began to have bradycardia with accompanying hypoxia. Pt stabilized and transported to ER and remained overnight for observation - same as incident #44
46	2015	2	12.7 kg	M	Dental caries	Restorative dental treatment at primary teeth B, C, D, E, F, G, L, M, & S	Surgery center	auto NIBP; EKG; SpO2; ETCO2; Temp	GA	Propofol (total of 400 mcg/kg/min); Alfenta (total of 100 mcg); Demerol (total of 30 mg); Atropine 0.26 mg; Epinephrine 150mg IM, 30/30/30mg IV; Albuterol 12 puffs	Pending	Dental anesthesiologist was providing the GA while another dentist was providing the restorative dental treatment. During the procedure, the patient was observed to have bradycardia with accompanying hypoxia. It was believed that the patient was having an adverse reaction to the anesthetic agents. The dental treatment was stopped and a code blue was called. Emergency meds and resuscitative measures were given until EMS arrived. The patient was transported to the hospital and was later discharged in good condition. The medical records indicate that the patient did not have an adverse reaction to the anesthetic agents but rather had breathing problems and stopped breathing during the procedure.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
47	2015	2	unknown	f	treatment of caries on teeth #A, #B, #E, #F, #G, #I, #K, & #T	caries treatment on teeth #A, #B, #E, #F, #G, #I, #K, & #T under oral sedation	dental office	heart rate, oxygen saturation	CS	25mg Vistaril, 6.6mg Versed, 30 minutes of 30% N2O	pending	Patient presented for treatment of caries under conscious sedation, parents transported to emergency later in day due to lethargy, swollen upper lip, and significant bruising. Patient discharged the same day.
48	2015	3.5	unknown	F	Filling	Filling	Dental Office	Unknown	CS	Unknown	Pending	3 year old patient had allergic reaction to unknown substance at dental office after treatment. Patient was taken to ER by mother several hours after treatment.
49	2015	8	unknown	Unknown	Extraction	Extraction	Oral Surgery Office	unknown	GA	unknown	Pending	Pedio Patient under GA, Laryngospasm and admitted to Hospital for observation. No Complications

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
50	2015	14	70lbs	M	Oral Surgery	Oral Surgery	University Dental Clinic	O2 Sat., Temp., BP, Pulse Ox. EKG, et co2	GA	Propofol, Fentanyl, Midazolam, Decadron, zofran, toradol	No Violation	Patient was transferred to hospital from recovery with low O2 Saturation Level, Bleeding Control, and Aspiration Pneumonia. Two oral surgeons and two anesthesiologist were present during procedure. Same as incident #s 51, 52, 53
51	2015	14	70lbs	M	Oral Surgery	Oral Surgery	University Dental Clinic	O2 Sat., Temp., BP, Pulse Ox. EKG, et co2	GA	Propofol, Fentanyl, Midazolam, Decadron, zofran, toradol	No Violation	Patient was transferred to hospital from recovery with low O2 Saturation Level, Bleeding Control, and Aspiration Pneumonia. Two oral surgeons and two anesthesiologist were present during procedure. Same as incident #s 50, 52, 53
52	2015	14	70lbs	M	Oral Surgery	Oral Surgery	University Dental Clinic	O2 Sat., Temp., BP, Pulse Ox. EKG, et co2	GA	Propofol, Fentanyl, Midazolam, Decadron, zofran, toradol	No Violation	Patient was transferred to hospital from recovery with low O2 Saturation Level, Bleeding Control, and Aspiration Pneumonia. Two oral surgeons and two anesthesiologist were present during procedure. same as incident #s 50, 51, 53

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
53	2015	14	70lbs	M	Oral Surgery	Oral Surgery	University Dental Clinic	O2 Sat., Temp., BP, Pulse Ox. EKG, et co2	GA	Propofol, Fentanyl, Midazolam, Decadron, zofran, toradol	No Violation	Patient was transferred to hospital from recovery with low O2 Saturation Level, Bleeding Control, and Aspiration Pneumonia. Two oral surgeons and two anesthesiologist were present during procedure. Same as incident #s 50, 51, 52
54	2015	15	unknown	M	3rd Molars Ext.	3rd Molar Ext.	Oral Surgery	O2, EKG, NI BP, SPO2, Pulse Ox.	GA	Midazolam, Fentanyl, Ketalar, Lidocaine W/Epi, xanax, Septocaine, Rubinul, Versed, Naloxome, Romazicom	Pending	Patient was slow to recover from GA and was sent to the hospital for treatment and overnight stay.

Summary Report of Pediatric Hospitalization  
 Reports Received from 1/1/10 - 12/31/15

Incident #	Year	Age	Weight	Sex	Primary Diagnosis	Procedure Performed	Setting	Monitor Type	GA or CS	Medication Used	DBC Findings	Summary
55	2015	21	125lbs	M	X-Rays, Cleaning, Exam	X-rays, Cleaning, Exam	Dental Office	Pulse Ox., NI BP, ECG, Temp. Capnography	GA	Propofol 200mg, Versed 2mg, Ondansetron 4mg, decadron 6mg, 500 ml NiCP 9%	No Violation	21 year old Autistic male patient started vomiting during sedation. Suctioning was performed, and patient was transported to hospital for admission and hospitalization. No particulate found in lungs by pulmonologist. Same as incident #56
56	2015	21	125lbs	M	X-Rays, Cleaning, Exam	X-rays, Cleaning, Exam	Dental Office	Pulse Ox., NI BP, ECG, Temp. Capnography	CS	Propofol 200mg, Versed 2mg, Ondansetron 4mg, decadron 6mg, 500 ml NuCP 9%	No Violation	21 year old Autistic male patient started vomiting during sedation. Suctioning was performed, and patient was transported to hospital for admission and hospitalization. No particulate found in lungs by pulmonologist. Same as incident #55



## MEMORANDUM

<b>DATE</b>	June 8, 2016
<b>TO</b>	Legislative and Regulatory Committee Members
<b>FROM</b>	Lusine M Sarkisyan, Legislative & Regulatory Analyst
<b>SUBJECT</b>	<b>Agenda Item 19A:</b> 2016 Tentative Legislative Calendar – Information Only

The 2016 Tentative Legislative Calendars are enclosed.

**Action Requested:**  
No action necessary.

# 2016 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE  
10/7/2015

## DEADLINES

JANUARY						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY						
S	M	T	W	TH	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29					

MARCH						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY						
S	M	T	W	TH	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

- Jan. 1** Statutes take effect (Art. IV, Sec. 8(c)).
- Jan. 4** Legislature **reconvenes** (J.R. 51(a)(4)).
- Jan. 10** Budget must be submitted by Governor (Art. IV, Sec. 12 (a)).
- Jan. 15** Last day for **policy committees** to hear and report to Fiscal Committees fiscal bills introduced in their house in the odd-numbered year. (J.R. 61(b)(1)).
- Jan. 18** Martin Luther King, Jr. Day observed.
- Jan. 22** Last day for any committee to hear and report to the **Floor** bills introduced in their house in 2015 (J.R. 61(b)(2)). Last day to submit **bill requests** to the Office of Legislative Counsel.
- Jan. 31** Last day for each house to **pass bills introduced in that house in the** odd-numbered year (J.R. 61(b)(3)), (Art. IV, Sec. 10(c)).

- Feb. 15** Presidents' day observed.
- Feb. 19** Last day for bills to be **introduced** (J.R. 61(b)(4), (J.R. 54(a)).

- Mar. 17** **Spring Recess** begins upon adjournment (J.R. 51(b)(1)).
- Mar. 28** Legislature reconvenes from **Spring Recess** (J.R. 51(b)(1)).

- Apr. 1** Cesar Chavez Day Observed.
- Apr. 22** Last day for **policy committees** to hear and report to Fiscal Committees **fiscal bills** introduced in their house (J.R. 61(b)(5)).

- May 6** Last day for **policy committees** to hear and report to the Floor **nonfiscal** bills introduced in their house (J.R. 61(b)(6)).
- May 13** Last day for **policy committees** to meet prior to June 6 (J.R. 61(b)(7)).
- May 27** Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61 (b)(8)). Last day for **fiscal committees** to meet prior to June 6 (J.R. 61 (b)(9)).
- May 30** Memorial Day observed.
- May 31 - June 3** **Floor Session only.** No committee may meet for any purpose (J.R. 61(b)(10)).

\*Holiday schedule subject to Senate Rules committee approval

## 2016 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE  
10/7/2015

JUNE						
S	M	T	W	TH	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

- June 3** Last day for each house to pass bills introduced in that house (J.R. 61(b)(11)).
- June 6** Committee meetings may resume (J.R. 61(b)(12)).
- June 15** Budget Bill must be passed by **midnight** (Art. IV, Sec. 12(c)(3)).
- June 30** Last day for a legislative measure to qualify for the Nov. 8 General election ballot (Elections Code Sec. 9040).

JULY						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

- July 1** Last day for **policy committees** to meet and report bills (J.R. 61(b)(13)). **Summer Recess** begins upon adjournment provided the Budget Bill has been passed (J.R. 51(b)(2)).
- July 4** Independence Day observed.

AUGUST						
S	M	T	W	TH	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

- Aug. 1** Legislature reconvenes from **Summer Recess** (J.R. 51(b)(2)).
- Aug. 12** Last day for **fiscal committees** to meet and report bills (J.R. 61(b)(14)).
- Aug. 15 - 31 Floor Session only.** No committees may meet for any purpose (J.R. 61(b)(15)).
- Aug. 19** Last day to **amend** on the Floor (J.R. 61(b)(16)).
- Aug. 31** Last day for **each house to pass bills**, except bills that take effect immediately or bills in Extraordinary Session (Art. IV, Sec. 10(c)), (J.R. 61(b)(17)).  
**Final Recess** begins upon adjournment (J.R. 51(b)(3)).

### IMPORTANT DATES OCCURRING DURING FINAL RECESS

#### **2016**

- Sept. 30 Last day for Governor to sign or veto bills passed by the Legislature before Sept. 1 and in the Governor's possession on or after Sept. 1 (Art. IV, Sec.10(b)(2)).
- Nov. 8 General Election.
- Nov. 30 Adjournment *Sine Die* at midnight (Art. IV, Sec. 3(a)).
- Dec. 5 12 Noon convening of the 2017-18 Regular Session (Art. IV, Sec. 3(a)).

#### **2017**

- Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

\*Holiday schedule subject to Senate Rules committee approval





## MEMORANDUM

<b>DATE</b>	July 5, 2016
<b>TO</b>	Legislative & Regulatory Committee Members
<b>FROM</b>	Lusine M Sarkisyan, Legislative & Regulatory Analyst
<b>SUBJECT</b>	<b>Agenda Item 19B:</b> Discussion and Possible Action on Legislation

Board staff is currently tracking eighteen (18) bills, pertaining to the Dental Board, healing arts boards, and statutes within the Business and Professions Code. Those bills that may directly impact the Board and have not failed to meet legislative deadlines will be discussed today.

The following bills have been listed for **informational purposes only**; no discussion or action will be taken during this agenda item. These bills have either failed to meet legislative deadlines and will no longer be moving through the legislative process or do not apply to the Board.

Bill Number	Author	Bill Title	Status
<b>AB 1707</b>	Linder	Public Records: Response to Request	Failed to Pass First House
<b>AB 2048</b>	Gray	National Health Service Corps State Loan Repayment Program	Does Not Apply to the Board
<b>AB 2207</b>	Wood	Medi-Cal: Dental Program	<a href="http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2207">http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2207</a> Senate Appropriations
<b>AB 2744</b>	Gordon	Healing Arts: Referrals	<a href="http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2744">http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2744</a> Senate Appropriations
<b>SB 1033</b>	Hill	Medical Professionals: Probation	Senate Inactive
<b>SB 1039</b>	Hill	Professions and Vocations	Assembly Appropriations

<b>SB 1098</b>	Cannella	Medi-Cal: Dental Services: Advisory Group	<a href="http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB1098">http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB1098</a>
			Assembly Appropriations
<b>SB 1195</b>	Hill	Professions and Vocations: Licenses: Military Service	Senate Inactive
<b>SB 1217</b>	Stone	Healing Arts: Reporting Requirements: Professional Liability	Failed to Pass First House

The following bills will be discussed by the Committee at this meeting. These are the same bills that the Committee discussed and took action on during its May 2016 meeting that are still progressing through the 2016 legislative process. Copies of each of these bills and staff analyses are enclosed in the meeting packet which were last updated as of July 31, 2016. Staff will continue to monitor the bills as they proceed through the legislative process and provide an update during the Board meeting should any changes have been made.

<b>Bill Number</b>	<b>Author</b>	<b>Bill Title</b>	<b>Status</b>
<b>AB 2235</b>	Thurmond	Board of Dentistry. Pediatric Anesthesia: Committee	Senate Appropriations
<b>AB 2331</b>	Dababneh	Dentistry: Applicants to Practice	Senate Appropriations
<b>AB 2485</b>	Santiago	Dental Corps Loan Repayment Program	Senate Appropriations
<b>AB 2859</b>	Low	Professions and Vocations: Retired Category: Licenses	Senate Appropriations
<b>SB 482</b>	Lara	Controlled Substances: CURES Database	Assembly Appropriations
<b>SB 1155</b>	Morrell	Professions and Vocations: Licenses: Military Service	Assembly Appropriations
<b>SB 1348</b>	Cannella	Licensure Applications: Military Experience	Assembly
<b>SB 1444</b>	Hertzberg	State Government: Computerized Personal Information Security Plans	Assembly Appropriations
<b>SB 1478</b>	Hill	Healing Arts	Assembly

Staff has provided a matrix of the tracked legislation disclosing information regarding each bill's status and Board's positions. Staff has provided copies of each bill in their most recent version, accompanied by staff analyses.

The following Web sites are excellent resources for viewing proposed legislation and finding additional information:

- [www.senate.ca.gov](http://www.senate.ca.gov)
- [www.assembly.ca.gov](http://www.assembly.ca.gov)
- [www.leginfo.ca.gov](http://www.leginfo.ca.gov)

**Action Requested:**

The Legislative and Regulatory Committee may recommend the Board take one of the following actions regarding each bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

Staff recommendations regarding Board action are included on the individual bill's analysis.

### Legislative Bill Matrix

House	Bill No.	Bill Name	Author	Status	Board Position
Assembly	1707	<u>Public Records: Response to Request</u>	Eric Linder	Failed passage	watch/May 2016
Assembly	2048	<u>National Health Service Corps State Loan Repayment Program</u>	Adam Gray	6/30 referred to Committee On Appropriations	Watch/March 2016
Assembly	2207	<u>Medi-Cal: Dental Program</u>	Jim Wood	6/28 Re-referred to Committee on Appropriations	
Assembly	2235	<u>Board of Dentistry: Pediatric Anesthesia: Committee (BPC add 1601.4)</u>	Tony Thurmond	6/29 Amended and re-referred to Committee on Appropriations	Watch/March 2016 Support in Concept with Revisions/May 2016
Assembly	2331	<u>Dentistry: Applicants to Practice (BPC 1632 &amp; 1632.6)</u>	Matt Dababneh	6/28 Re-referred to Committee on Appropriations	Watch/March 2016/May 2016
Assembly	2485	<u>Dental Corps Loan Repayment Program</u>	Miguel Santiago	6/28 Do pass and re-refer to Committee on Appropriations	Watch/March 2016
Assembly	2744	<u>Healing Arts: Referrals</u>	Richard Gordon	6/16 Read second time and amended re-referred to Senate Appropriations	
Assembly	2859	<u>Professions and vocations: retired category: licenses</u>	Evan Low	6/15 Read second time and amended. Re-referred to Committee on Appropriations	Letter of Concern/May 2016
Senate	482	<u>Controlled Substances: CURES database</u>	Ricardo Lara	6/29 Committee on Appropriations hearing canceled at request of author.	Watch/March 2016
Senate	1033	<u>Medical Board: Disclosure of Probationary Status (BPC 803.1, 2027, and 2228)</u>	Jerry Hill	6/02 Ordered to Senate Inactive file at request of Senator Monning	Watch/March 2016/May 2016
Senate	1039	<u>Professions and Vocations (Omnibus Bill)</u>	Senate Committee on Business, Professions and Economic Development	6/30 re-referred to Committee on Appropriations	Watch/March 2016 Support if amended to add back in language/May 2016
Senate	1098	<u>Medi-Cal: Dental Services: Advisory Group</u>	Anthony Cannella	6/30 re-referred to Committee on Appropriations	
senate	1155	<u>Professions and Vocations: Licenses: Military Service</u>	Mike Morrell	6/29 Committee on Appropriations	Watch/May 2016
Senate	1195	<u>Professions and Vocations: Board Actions: Competitive Impact</u>	Jerry Hill	6/02 Ordered to Senate Inactive at request of Senator Hill	Watch/May 2016
Senate	1217	<u>Healing Arts: Reporting Requirements: Professional Liability (BPC 800, 801, 801.1, 802)</u>	Jeff Stone	4/18 failed Senate Committee on SBPED, but reconsideration granted;Failed passage	Watch/March 2016/ may 2016
senate	1348	<u>Licensure Applications: Military Experience</u>	Anthony Cannella	6/30 Read second time. Ordered Consent Calendar	Watch/May 2016
Senate	1444	<u>State government: computerized personal information security plans</u>	Bob Hertzberg	6/28 Re-referred to Committee On Appropriations	Watch/May 2016
Senate	1478	<u>Healing arts</u>	Senate Committee on Business, Professions and Economic Development	6/30 Ordered to third reading; Consent Calendar	Support/May 2016

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
AUGUST 2016 BOARD MEETING**

---

---

<b>BILL NUMBER:</b>	Assembly Bill 2235	<b>SPONSOR:</b>	American Academy of Pediatrics, California
<b>AUTHOR:</b>	Assembly Member Tony Thurmond	<b>INTRODUCED:</b>	2/18/2016
<b>VERSION:</b>	Amended in Senate 6/29/2016	<b>BILL LOCATION:</b>	Senate Appropriations
<b>BILL STATUS:</b>	06/29/2016 – Amended and re-referred to Com. On APPR.	<b>RELATED BILLS:</b>	
<b>SUBJECT:</b>	Board of Dentistry: Pediatric Anesthesia: Committee		

**SUMMARY**

In amended form, this bill would require the Dental Board of California (Board) to do the following:

- By January 1, 2017, report to the legislature on whether current statutes and regulations for the administration and monitoring of pediatric anesthesia in dentistry provide adequate protection for pediatric dental patients;
- Make the report publically available on the Board's internet website;
- Provide a report on pediatric deaths related to general anesthesia in dentistry at the time of its sunset review;
- Create Board approved reporting forms of the specified information; and
- Assess a penalty on any licensee who fails to submit the required report.

This bill would also require licensees to do the following:

- Complete the Board approved reporting form as incidents occur relating to general anesthesia or conscious sedation; and
- Obtain written informed consent of a patient prior to administering general anesthesia

Additionally, this proposed bill encourages the Board to encourage all dental sedation providers in California to submit data regarding adverse events to a pediatric sedation research database maintained by an unidentified nonprofit organization.

**ANALYSIS**

This bill mirrors a request submitted to the Board President by Senate Committee on Business Professions and Economic Development Chair Jerry Hill. However, there are additional requirements such as creating a Board approved reporting form for licensees to utilize in order to submit incident reports where general anesthesia or conscious sedation is used; making the report public on the Board's internet website; penalizing licensees if they fail to submit an incident report with the required information; and requiring licensees to incorporate a statement as specified within their written informed consent forms.

This would require the hiring of additional staff to perform the journey-level work required by this bill. The additional staff member will become the liaison between the Board, subcommittee, legislature, licensees, professional organizations, and other stakeholders. The staff member will lead in the research and promulgation of regulations to be implemented once the subcommittee

provides the report; process incident reports; input data from the incident reports into a spreadsheet, and correspond with licensees should questions arise or inquiries be made. The fiscal impact as a result of this bill is the cost associated with hiring an additional staff member; the first year of hiring an associate governmental program analyst is \$120,000 and the ongoing costs will be \$104,000.

**REGISTERED SUPPORT/OPPOSITION (Last updated 6/13/2016)**

**Support:**

American Academy of Pediatrics, California (Sponsor)  
American Society of Dentist Anesthesiologists  
California Association of Nurse Anesthetists  
California Society of Anesthesiologists  
The Children's Partnership  
Numerous individuals

**Support if Amended:**

California Dental Association

**Oppose unless Amended:**

Oral and Facial Surgeons of California

**BOARD POSITION**

The Board took a position of "Support in Concept with Suggested Revisions" on the bill during the May 2016 Board meeting. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

Staff recommends the Committee to continue to maintain its "Support in Concept" position on this bill for the following reasons:

1. The March 2016 appointed subcommittee is working on the request made by Senate Business, Professions and Economic Development Chair, Senator Jerry Hill, which mirrors this proposed bill in pertinent parts; and
2. The language continues to evolve.

AMENDED IN SENATE JUNE 29, 2016  
AMENDED IN SENATE JUNE 20, 2016  
AMENDED IN SENATE JUNE 9, 2016  
AMENDED IN ASSEMBLY APRIL 11, 2016  
AMENDED IN ASSEMBLY MARCH 31, 2016  
CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 2235**

---

---

**Introduced by Assembly Member Thurmond**

February 18, 2016

---

---

An act to amend Sections 1680 and 1682 of, and to add Section 1601.4 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2235, as amended, Thurmond. Board of Dentistry: pediatric anesthesia: committee.

The Dental Practice Act provides for the licensure and regulation of dentists by the Dental Board of California. That act authorizes a committee of the board to evaluate all suggestions or requests for regulatory changes related to the committee and to hold informational hearings in order to report and make appropriate recommendations to the board, after consultation with departmental legal counsel and the board's chief executive officer. The act requires a committee to include in any report regarding a proposed regulatory change, at a minimum, the specific language or the proposed change or changes and the reasons therefor, and any facts supporting the need for the change.

The act governs the use of general anesthesia, conscious sedation, and oral conscious sedation for pediatric and adult patients. The act makes it unprofessional conduct for a licensee to fail to report the death of a patient, or removal of a patient to a hospital or emergency center for medical treatment, that is related to a dental procedure, as specified. The act also makes it unprofessional conduct for any dentist to fail to obtain the written informed consent of a patient prior to administering general anesthesia or conscious sedation. In the case of a minor, the act requires that the consent be obtained from the child's parent or guardian.

~~This bill, which would be known as "Caleb's Law," would require the board, on or before February 1, 2017, to establish a committee to investigate whether the current statutes and regulations for the administration and monitoring of oral conscious sedation, conscious sedation, and general anesthesia provide adequate protection for pediatric dental patients. The bill would require the committee, on or before August 1, 2017, to review all incident reports and relevant investigatory information related to pediatric anesthesia in dentistry in the state for the years 2010 to 2016, inclusive, and to review the policies and guidelines of other states and national dental associations, as well as studies, to ensure that the state's statutes and regulations adequately protect pediatric dental patients. The bill would require the committee, on or before November 1, 2017, to present its findings in a report to the board, including any recommendations necessary to improve safety. The bill would require the board, on or before January 1, 2018, to provide to the Legislature the committee's recommendations, an evaluation of the committee's report, and the board's own recommendations and to make the report publicly available on the board's Internet Web site. The bill also would require the board to provide a report on pediatric deaths related to general anesthesia in dentistry at the time of its sunset review by the appropriate policy committees of the Legislature.~~

*This bill, which would be known as "Caleb's Law," would require the board, on or before January 1, 2017, to provide to the Legislature a report on whether current statutes and regulations for the administration and monitoring of pediatric anesthesia in dentistry provide adequate protection for pediatric dental patients and would require the board to make the report publicly available on the board's Internet Web site. The bill also would require the board to provide a report on pediatric deaths related to general anesthesia in dentistry at*



*the time of its sunset review by the appropriate policy committees of the Legislature.*

This bill would require that the report of the death of a patient, or removal of a patient to a hospital or emergency center for medical treatment, be on a form or forms approved by the board and that the report include specified information. The bill authorizes the board to assess a penalty on any licensee who fails to make the required report.

This bill, with regard to obtaining written informed consent for general anesthesia or conscious sedation in the case of a minor, would require that the written informed consent include specified information regarding anesthesia, as provided.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. This act shall be known, and may be cited, as  
2 “Caleb’s Law.”

3 SEC. 2. It is the Legislature’s intent, to the extent that funds  
4 are appropriated for this purpose, that the board encourage all  
5 dental sedation providers in California to submit data regarding  
6 pediatric sedation events to a pediatric sedation research database  
7 maintained by a nonprofit organization. It is the goal of the  
8 Legislature that the data submitted will be used to formulate a  
9 systems-based approach to improve the quality of services provided  
10 to pediatric dental anesthesia patients in outpatient settings.

11 SEC. 3. Section 1601.4 is added to the Business and Professions  
12 Code, to read:

13 1601.4. (a) ~~The board, on or before February 1, 2017, shall~~  
14 ~~establish a committee to investigate whether current statutes and~~  
15 ~~regulations for the administration and monitoring of oral conscious~~  
16 ~~sedation, conscious sedation, and general anesthesia provide~~  
17 ~~adequate protection for pediatric dental patients. For the purpose~~  
18 ~~of this section, a pediatric dental patient is a person under 21 years~~  
19 ~~of age.~~

20 (b) ~~On or before August 1, 2017, the committee shall review~~  
21 ~~all incident reports and relevant investigatory information related~~  
22 ~~to pediatric anesthesia in dentistry in the state for the years 2010~~  
23 ~~to 2016, inclusive, and shall review the policies and guidelines of~~  
24 ~~other states and national dental associations as well as studies~~

1 regarding the use of pediatric anesthesia to ensure that the state's  
2 statutes and regulations adequately protect pediatric dental patients.  
3 The committee also shall review statutory and regulatory  
4 definitions relating to sedation and anesthesia and recommend any  
5 necessary revisions. The members of the committee shall agree  
6 not to disclose any confidential, privileged, or personally  
7 identifiable information contained in the dental board records,  
8 except as permitted by law.

9 (e) On or before November 1, 2017, the committee shall present  
10 its findings to the board in a report which shall include any  
11 recommendations necessary to improve safety during the  
12 administration and monitoring of oral conscious sedation, conscious  
13 sedation, and general anesthesia for pediatric dental patients.

14 (d) On or before January 1, 2018, the board shall provide to the  
15 Legislature the recommendations of the committee pursuant to  
16 subdivision (e), an evaluation of the report, and the board's own  
17 recommendations. The report shall be submitted in compliance  
18 with Section 9795 of the Government Code. The requirement for  
19 submitting a report imposed by this subdivision is inoperative on  
20 December 1, 2021, pursuant to Section 10231.5 of the Government  
21 Code. The board shall make the report publicly available on the  
22 board's Internet Web site, and shall include, but is not limited to,  
23 the following anonymized data from each incident reviewed, if  
24 available from records in the board's possession, custody, or  
25 control, including investigatory reports: the age of the patient; the  
26 patient's primary diagnosis; the procedures performed; the sedation  
27 setting; the medications used; the monitoring equipment used; the  
28 category of the provider responsible for sedation oversight; the  
29 category of the provider delivering sedation; the category of the  
30 provider monitoring the patient during sedation; whether the person  
31 supervising the sedation performed one or more of the procedures;  
32 the category of the provider conducting resuscitation measures;  
33 and the resuscitation equipment utilized.

34 (e) For the purposes of subdivision (d), categories of provider  
35 are: General Dentist, Pediatric Dentist, Oral Surgeon, Dentist  
36 Anesthesiologist, Physician Anesthesiologist, Dental Assistant,  
37 Registered Dental Assistant, Dental Sedation Assistant, Registered  
38 Nurse, Certified Registered Nurse Anesthetist, or Other.

1 ~~(f) The board shall provide a report on pediatric deaths related~~  
2 ~~to general anesthesia in dentistry at the time of its sunset review~~  
3 ~~pursuant to subdivision (d) of Section 1601.1.~~

4 *(a) On or before January 1, 2017, the board shall provide to*  
5 *the Legislature a report on whether current statutes and*  
6 *regulations for the administration and monitoring of pediatric*  
7 *anesthesia in dentistry provide adequate protection for pediatric*  
8 *dental patients. The report shall be submitted in compliance with*  
9 *Section 9795 of the Government Code. The requirement for*  
10 *submitting a report imposed by this subdivision is inoperative on*  
11 *December 1, 2021, pursuant to Section 10231.5 of the Government*  
12 *Code. The board shall make the report publicly available on the*  
13 *board's Internet Web site.*

14 *(b) The board shall provide a report on pediatric deaths related*  
15 *to general anesthesia in dentistry at the time of its sunset review*  
16 *pursuant to subdivision (d) of Section 1601.1.*

17 SEC. 4. Section 1680 of the Business and Professions Code is  
18 amended to read:

19 1680. Unprofessional conduct by a person licensed under this  
20 chapter is defined as, but is not limited to, any one of the following:

21 (a) The obtaining of any fee by fraud or misrepresentation.

22 (b) The employment directly or indirectly of any student or  
23 suspended or unlicensed dentist to practice dentistry as defined in  
24 this chapter.

25 (c) The aiding or abetting of any unlicensed person to practice  
26 dentistry.

27 (d) The aiding or abetting of a licensed person to practice  
28 dentistry unlawfully.

29 (e) The committing of any act or acts of sexual abuse,  
30 misconduct, or relations with a patient that are substantially related  
31 to the practice of dentistry.

32 (f) The use of any false, assumed, or fictitious name, either as  
33 an individual, firm, corporation, or otherwise, or any name other  
34 than the name under which he or she is licensed to practice, in  
35 advertising or in any other manner indicating that he or she is  
36 practicing or will practice dentistry, except that name as is specified  
37 in a valid permit issued pursuant to Section 1701.5.

38 (g) The practice of accepting or receiving any commission or  
39 the rebating in any form or manner of fees for professional services,

1 radiograms, prescriptions, or other services or articles supplied to  
2 patients.

3 (h) The making use by the licensee or any agent of the licensee  
4 of any advertising statements of a character tending to deceive or  
5 mislead the public.

6 (i) The advertising of either professional superiority or the  
7 advertising of performance of professional services in a superior  
8 manner. This subdivision shall not prohibit advertising permitted  
9 by subdivision (h) of Section 651.

10 (j) The employing or the making use of solicitors.

11 (k) The advertising in violation of Section 651.

12 (l) The advertising to guarantee any dental service, or to perform  
13 any dental operation painlessly. This subdivision shall not prohibit  
14 advertising permitted by Section 651.

15 (m) The violation of any of the provisions of law regulating the  
16 procurement, dispensing, or administration of dangerous drugs,  
17 as defined in Chapter 9 (commencing with Section 4000) or  
18 controlled substances, as defined in Division 10 (commencing  
19 with Section 11000) of the Health and Safety Code.

20 (n) The violation of any of the provisions of this division.

21 (o) The permitting of any person to operate dental radiographic  
22 equipment who has not met the requirements of Section 1656.

23 (p) The clearly excessive prescribing or administering of drugs  
24 or treatment, or the clearly excessive use of diagnostic procedures,  
25 or the clearly excessive use of diagnostic or treatment facilities,  
26 as determined by the customary practice and standards of the dental  
27 profession.

28 Any person who violates this subdivision is guilty of a  
29 misdemeanor and shall be punished by a fine of not less than one  
30 hundred dollars (\$100) or more than six hundred dollars (\$600),  
31 or by imprisonment for a term of not less than 60 days or more  
32 than 180 days, or by both a fine and imprisonment.

33 (q) The use of threats or harassment against any patient or  
34 licensee for providing evidence in any possible or actual  
35 disciplinary action, or other legal action; or the discharge of an  
36 employee primarily based on the employee's attempt to comply  
37 with the provisions of this chapter or to aid in the compliance.

38 (r) Suspension or revocation of a license issued, or discipline  
39 imposed, by another state or territory on grounds that would be  
40 the basis of discipline in this state.

- 1 (s) The alteration of a patient's record with intent to deceive.
- 2 (t) Unsanitary or unsafe office conditions, as determined by the  
3 customary practice and standards of the dental profession.
- 4 (u) The abandonment of the patient by the licensee, without  
5 written notice to the patient that treatment is to be discontinued  
6 and before the patient has ample opportunity to secure the services  
7 of another dentist, registered dental hygienist, registered dental  
8 hygienist in alternative practice, or registered dental hygienist in  
9 extended functions and provided the health of the patient is not  
10 jeopardized.
- 11 (v) The willful misrepresentation of facts relating to a  
12 disciplinary action to the patients of a disciplined licensee.
- 13 (w) Use of fraud in the procurement of any license issued  
14 pursuant to this chapter.
- 15 (x) Any action or conduct that would have warranted the denial  
16 of the license.
- 17 (y) The aiding or abetting of a licensed dentist, dental assistant,  
18 registered dental assistant, registered dental assistant in extended  
19 functions, dental sedation assistant permitholder, orthodontic  
20 assistant permitholder, registered dental hygienist, registered dental  
21 hygienist in alternative practice, or registered dental hygienist in  
22 extended functions to practice dentistry in a negligent or  
23 incompetent manner.
- 24 (z) (1) The failure to report to the board in writing within seven  
25 days any of the following: (A) the death of his or her patient during  
26 the performance of any dental or dental hygiene procedure; (B)  
27 the discovery of the death of a patient whose death is related to a  
28 dental or dental hygiene procedure performed by him or her; or  
29 (C) except for a scheduled hospitalization, the removal to a hospital  
30 or emergency center for medical treatment of any patient to whom  
31 oral conscious sedation, conscious sedation, or general anesthesia  
32 was administered, or any patient as a result of dental or dental  
33 hygiene treatment. With the exception of patients to whom oral  
34 conscious sedation, conscious sedation, or general anesthesia was  
35 administered, removal to a hospital or emergency center that is  
36 the normal or expected treatment for the underlying dental  
37 condition is not required to be reported. Upon receipt of a report  
38 pursuant to this subdivision the board may conduct an inspection  
39 of the dental office if the board finds that it is necessary. A dentist  
40 shall report to the board all deaths occurring in his or her practice

1 with a copy sent to the Dental Hygiene Committee of California  
2 if the death was the result of treatment by a registered dental  
3 hygienist, registered dental hygienist in alternative practice, or  
4 registered dental hygienist in extended functions. A registered  
5 dental hygienist, registered dental hygienist in alternative practice,  
6 or registered dental hygienist in extended functions shall report to  
7 the Dental Hygiene Committee of California all deaths occurring  
8 as the result of dental hygiene treatment, and a copy of the  
9 notification shall be sent to the board.

10 (2) The report required by this subdivision shall be on a form  
11 or forms approved by the board. The form or forms approved by  
12 the board shall require the licensee to include, but not be limited  
13 to, the following information for cases in which patients received  
14 anesthesia: the date of the procedure; the patient’s age in years  
15 and months, weight, and sex; the patient’s American Society of  
16 Anesthesiologists (ASA) physical status; the patient’s primary  
17 diagnosis; the patient’s coexisting diagnoses; the procedures  
18 performed; the sedation setting; the medications used; the  
19 monitoring equipment used; the category of the provider  
20 responsible for sedation oversight; the category of the provider  
21 delivering sedation; the category of the provider monitoring the  
22 patient during sedation; whether the person supervising the sedation  
23 performed one or more of the procedures; the planned airway  
24 management; the planned depth of sedation; the complications  
25 that occurred; a description of what was unexpected about the  
26 airway management; whether there was transportation of the patient  
27 during sedation; the category of the provider conducting  
28 resuscitation measures; and the resuscitation equipment utilized.  
29 Disclosure of individually identifiable patient information shall  
30 be consistent with applicable law. A report required by this  
31 subdivision shall not be admissible in any action brought by a  
32 patient of the licensee providing the report.

33 (3) For the purposes of paragraph (2), categories of provider  
34 are: General Dentist, Pediatric Dentist, Oral Surgeon, Dentist  
35 Anesthesiologist, Physician Anesthesiologist, Dental Assistant,  
36 Registered Dental Assistant, Dental Sedation Assistant, Registered  
37 Nurse, Certified Registered Nurse Anesthetist, or Other.

38 (4) The form shall state that this information shall not be  
39 considered an admission of guilt, but is for educational, data, or  
40 investigative purposes.

1 (5) The board may assess a penalty on any licensee who fails  
2 to report an instance of an adverse event as required by this  
3 subdivision. The penalty is a maximum fine of one hundred dollars  
4 (\$100) per day not reported after the initial seven-day reporting  
5 period. The licensee may dispute the failure to file within 10 days  
6 of receiving notice that the board had assessed a penalty against  
7 the licensee.

8 (aa) Participating in or operating any group advertising and  
9 referral services that are in violation of Section 650.2.

10 (ab) The failure to use a fail-safe machine with an appropriate  
11 exhaust system in the administration of nitrous oxide. The board  
12 shall, by regulation, define what constitutes a fail-safe machine.

13 (ac) Engaging in the practice of dentistry with an expired license.

14 (ad) Except for good cause, the knowing failure to protect  
15 patients by failing to follow infection control guidelines of the  
16 board, thereby risking transmission of bloodborne infectious  
17 diseases from dentist, dental assistant, registered dental assistant,  
18 registered dental assistant in extended functions, dental sedation  
19 assistant permitholder, orthodontic assistant permitholder,  
20 registered dental hygienist, registered dental hygienist in alternative  
21 practice, or registered dental hygienist in extended functions to  
22 patient, from patient to patient, and from patient to dentist, dental  
23 assistant, registered dental assistant, registered dental assistant in  
24 extended functions, dental sedation assistant permitholder,  
25 orthodontic assistant permitholder, registered dental hygienist,  
26 registered dental hygienist in alternative practice, or registered  
27 dental hygienist in extended functions. In administering this  
28 subdivision, the board shall consider referencing the standards,  
29 regulations, and guidelines of the State Department of Public  
30 Health developed pursuant to Section 1250.11 of the Health and  
31 Safety Code and the standards, guidelines, and regulations pursuant  
32 to the California Occupational Safety and Health Act of 1973 (Part  
33 1 (commencing with Section 6300) of Division 5 of the Labor  
34 Code) for preventing the transmission of HIV, hepatitis B, and  
35 other blood-borne pathogens in health care settings. The board  
36 shall review infection control guidelines, if necessary, on an annual  
37 basis and proposed changes shall be reviewed by the Dental  
38 Hygiene Committee of California to establish a consensus. The  
39 committee shall submit any recommended changes to the infection  
40 control guidelines for review to establish a consensus. As

1 necessary, the board shall consult with the Medical Board of  
2 California, the California Board of Podiatric Medicine, the Board  
3 of Registered Nursing, and the Board of Vocational Nursing and  
4 Psychiatric Technicians, to encourage appropriate consistency in  
5 the implementation of this subdivision.

6 The board shall seek to ensure that all appropriate dental  
7 personnel are informed of the responsibility to follow infection  
8 control guidelines, and of the most recent scientifically recognized  
9 safeguards for minimizing the risk of transmission of bloodborne  
10 infectious diseases.

11 (ae) The utilization by a licensed dentist of any person to  
12 perform the functions of any registered dental assistant, registered  
13 dental assistant in extended functions, dental sedation assistant  
14 permitholder, orthodontic assistant permitholder, registered dental  
15 hygienist, registered dental hygienist in alternative practice, or  
16 registered dental hygienist in extended functions who, at the time  
17 of initial employment, does not possess a current, valid license or  
18 permit to perform those functions.

19 (af) The prescribing, dispensing, or furnishing of dangerous  
20 drugs or devices, as defined in Section 4022, in violation of Section  
21 2242.1.

22 SEC. 5. Section 1682 of the Business and Professions Code is  
23 amended to read:

24 1682. In addition to other acts constituting unprofessional  
25 conduct under this chapter, it is unprofessional conduct for:

26 (a) Any dentist performing dental procedures to have more than  
27 one patient undergoing conscious sedation or general anesthesia  
28 on an outpatient basis at any given time unless each patient is being  
29 continuously monitored on a one-to-one ratio while sedated by  
30 either the dentist or another licensed health professional authorized  
31 by law to administer conscious sedation or general anesthesia.

32 (b) Any dentist with patients recovering from conscious sedation  
33 or general anesthesia to fail to have the patients closely monitored  
34 by licensed health professionals experienced in the care and  
35 resuscitation of patients recovering from conscious sedation or  
36 general anesthesia. If one licensed professional is responsible for  
37 the recovery care of more than one patient at a time, all of the  
38 patients shall be physically in the same room to allow continuous  
39 visual contact with all patients and the patient to recovery staff  
40 ratio should not exceed three to one.



1 (c) Any dentist with patients who are undergoing conscious  
2 sedation to fail to have these patients continuously monitored  
3 during the dental procedure with a pulse oximeter or similar or  
4 superior monitoring equipment required by the board.

5 (d) Any dentist with patients who are undergoing conscious  
6 sedation to have dental office personnel directly involved with the  
7 care of those patients who are not certified in basic cardiac life  
8 support (CPR) and recertified biennially.

9 (e) (1) Any dentist to fail to obtain the written informed consent  
10 of a patient prior to administering general anesthesia or conscious  
11 sedation. In the case of a minor, the consent shall be obtained from  
12 the child's parent or guardian.

13 (2) The written informed consent, in the case of a minor, shall  
14 include, but not be limited to, the following information:

15 "The administration and monitoring of general anesthesia may  
16 vary depending on the type of procedure, the type of practitioner,  
17 the age and health of the patient, and the setting in which anesthesia  
18 is provided. Risks may vary with each specific situation. You are  
19 encouraged to explore all the options available for your child's  
20 anesthesia for his or her dental treatment, and consult with your  
21 dentist or pediatrician as needed."

22 (3) Nothing in this subdivision shall be construed to establish  
23 the reasonable standard of care for administering or monitoring  
24 oral conscious sedation, conscious sedation, or general anesthesia.

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
MAY 2016 BOARD MEETING**

---

---

<b>BILL NUMBER:</b>	Assembly Bill 2331		
<b>AUTHOR:</b>	Assembly Member Matt Dababneh	<b>SPONSOR:</b>	
<b>VERSION:</b>	Amended 6/16/2016	<b>INTRODUCED:</b>	2/18/2016
<b>BILL STATUS:</b>	6/28/2016 Do pass and referred to Com on APPR	<b>BILL LOCATION:</b>	Senate Appropriations
<b>SUBJECT:</b>	Dentistry: Applicants to Practice	<b>RELATED BILLS:</b>	

**SUMMARY**

Existing law requires each applicant for a license to practice dentistry to successfully complete specified examinations, including receiving a passing score on either a portfolio examination, as specified, or a clinical and written examination administered by the Western Regional Examining Board (WREB).

Additionally, existing law authorizes the Director of Finance to accept on behalf of the state any gift of real or personal property whenever he or she deems the gift and the terms and conditions thereof to be in the best interest of the state.

This bill would require the Dental Board of California (Board) to recognize an additional pathway to dental licensure in California by allowing an applicant to satisfy a portion of the licensure examination requirements by taking and successfully passing the examination developed by the American Board of Dental Examiners, Inc (ADEX). Additionally, this bill would specify that ADEX will pay all reasonable costs and expenses the Board incurs and would authorize the Director of Finance to accept funds for the purpose of implementing the ADEX examination which would be deposited into the Special Deposit Fund.

**ANALYSIS**

At this time, the potential impact of this bill upon the Dental Board of California (Board) is significant, as it would require the Board to conduct the occupational analyses prior to a psychometric evaluation validation of ADEX as required by Business and Professions Code (Code) Section 139.

The cost associated with the occupational analyses and the psychometric evaluation validation is addressed in this proposed bill by the addition of language regarding the acceptance of funds by the Director of Finance and the requirement of ADEX paying all reasonable costs and expenses incurred as a result of implementing the proposed bill.

Additional staff will be hired to process the ADEX examination and assist in the promulgation of regulations to implement the new pathway. The cost associated with hiring a staff services analyst is \$90,000 the first year and \$82,000 ongoing.

Furthermore, the Office of Information Services has determined that the costs associated in establishing the ADEX examination as a pathway is minor and absorbable as relating with BreEZe.

### **REGISTERED SUPPORT/OPPOSITION (As of 6/21/2016)**

#### **Support:**

American Board of Dental Examiners (Sponsor)  
California Dental Association

#### **Opposition:**

None on file.

### **BOARD POSITION**

The Board has taken a "WATCH" position on the bill. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

Staff recommends the Committee to take a "SUPPORT" position on this bill.

AMENDED IN SENATE JUNE 16, 2016  
AMENDED IN ASSEMBLY MAY 27, 2016  
AMENDED IN ASSEMBLY APRIL 12, 2016  
AMENDED IN ASSEMBLY MARCH 28, 2016  
CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 2331**

---

---

**Introduced by Assembly Member Dababneh**

February 18, 2016

---

---

An act to amend Section 1632 of, and to add Sections 1632.55 and 1632.7 to, the Business and Professions Code, relating to dentistry, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2331, as amended, Dababneh. Dentistry: applicants to practice.

The Dental Practice Act provides for the licensure and regulation of dentists and associated professions by the Dental Board of California within the Department of Consumer Affairs. The act requires each applicant for a license to practice dentistry to successfully complete specified examinations, including receiving a passing score on either a portfolio examination, as specified, or a clinical and written examination administered by the Western Regional Examining Board, which determines the passing score for that examination.

This bill would additionally allow an applicant to satisfy that examination requirement by receiving a passing score on the ~~Patient Centered Curriculum Integrated Dental Examination Format~~ *clinical and written examination* developed by the American Board of Dental Examiners, Inc., subject to prior review and approval of the examination

by the Office of Professional Examination Services, as provided, delivery of this review to the Dental Board of California, and payment of specified expenses incurred by the board.

Existing law authorizes the Director of Finance to accept on behalf of the state any gift of real or personal property whenever he or she deems the gift and the terms and conditions thereof to be in the best interest of the state. Existing law establishes the Special Deposit Fund, a continuously appropriated fund, which consists of money that is paid into it in trust pursuant to law when no other fund has been created to receive that money.

This bill would authorize the Director of Finance to accept funds for the purposes of reviewing and ~~implementing~~ *analyzing* the dental examination developed by the American Board of Dental Examiners, Inc., described above. Because these funds would be deposited in the Special Deposit Fund, a continuously appropriated fund, this bill would make an appropriation.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 1632 of the Business and Professions
- 2 Code is amended to read:
- 3 1632. (a) The board shall require each applicant to successfully
- 4 complete the Part I and Part II written examinations of the National
- 5 Board Dental Examination of the Joint Commission on National
- 6 Dental Examinations.
- 7 (b) The board shall require each applicant to successfully
- 8 complete an examination in California law and ethics developed
- 9 and administered by the board. The board shall provide a separate
- 10 application for this examination. The board shall ensure that the
- 11 law and ethics examination reflects current law and regulations,
- 12 and ensure that the examinations are randomized. Applicants shall
- 13 submit this application and required fee to the board in order to
- 14 take this examination. In addition to the aforementioned
- 15 application, the only other requirement for taking this examination
- 16 shall be certification from the dean of the qualifying dental school
- 17 attended by the applicant that the applicant has graduated, or will
- 18 graduate, or is expected to graduate. Applicants who submit
- 19 completed applications and certification from the dean at least 15

1 days prior to a scheduled examination shall be scheduled to take  
2 the examination. Successful results of the examination shall, as  
3 established by board regulation, remain valid for two years from  
4 the date that the applicant is notified of having passed the  
5 examination.

6 (c) Except as otherwise provided in Section 1632.5, the board  
7 shall require each applicant to have taken and received a passing  
8 score on one of the following:

9 (1) A portfolio examination of the applicant's competence to  
10 enter the practice of dentistry. This examination shall be conducted  
11 while the applicant is enrolled in a dental school program at a  
12 board-approved school located in California. This examination  
13 shall utilize uniform standards of clinical experiences and  
14 competencies, as approved by the board pursuant to Section 1632.1.  
15 The applicant shall pass a final assessment of the submitted  
16 portfolio at the end of his or her dental school program. Before  
17 any portfolio assessment may be submitted to the board, the  
18 applicant shall remit the required fee to the board to be deposited  
19 into the State Dentistry Fund, and a letter of good standing signed  
20 by the dean of his or her dental school or his or her delegate stating  
21 that the applicant has graduated or will graduate with no pending  
22 ethical issues.

23 (A) The portfolio examination shall not be conducted until the  
24 board adopts regulations to carry out this paragraph. The board  
25 shall post notice on its Internet Web site when these regulations  
26 have been adopted.

27 (B) The board shall also provide written notice to the Legislature  
28 and the Legislative Counsel when these regulations have been  
29 adopted.

30 (2) Either one of the following examinations:

31 (A) A clinical and written examination administered by the  
32 Western Regional Examining Board.

33 (B) ~~The Patient Centered Curriculum Integrated Dental~~  
34 ~~Examination Format~~ *clinical and written examination* developed  
35 by the American Board of Dental Examiners, Inc.

36 (d) Notwithstanding subdivision (b) of Section 1628, the board  
37 is authorized to do either of the following:

38 (1) Approve an application for examination from, and to  
39 examine an applicant who is enrolled in, but has not yet graduated  
40 from, a reputable dental school approved by the board.

1 (2) Accept the results of an examination described in paragraph  
2 (2) of subdivision (c) submitted by an applicant who was enrolled  
3 in, but had not graduated from, a reputable dental school approved  
4 by the board at the time the examination was administered.

5 In either case, the board shall require the dean of that school or  
6 his or her delegate to furnish satisfactory proof that the applicant  
7 will graduate within one year of the date the examination was  
8 administered or as provided in paragraph (1) of subdivision (c).

9 *(e) The board may determine the testing format, as related to*  
10 *patients, for the examination provided pursuant to subparagraph*  
11 *(B) of paragraph (2) of subdivision (c).*

12 SEC. 2. Section 1632.55 is added to the Business and  
13 Professions Code, to read:

14 1632.55. (a) Prior to implementation of subparagraph (B) of  
15 paragraph (2) of subdivision (c) of Section 1632, the department's  
16 Office of Professional Examination Services shall review the  
17 American Board of Dental Examiners, ~~Inc.~~, Inc. examination to  
18 ensure compliance with the requirements of Section 139 and to  
19 certify that the examination process meets those standards, and  
20 deliver this review to the Dental Board of California. If the  
21 department determines that the examination process fails to meet  
22 those standards, does not deliver the review to the Dental Board  
23 of California, or if the American Board of Dental Examiners, Inc.  
24 fails to pay the costs and expenses the board incurs, as described  
25 in subdivision (d), subparagraph (B) of paragraph (2) of subdivision  
26 (c) of Section 1632 shall not be implemented.

27 (b) The American Board of Dental Examiners, Inc. examination  
28 process shall be regularly reviewed by the department pursuant to  
29 Section 139.

30 (c) The American Board of Dental Examiners, Inc. examination  
31 shall meet the mandates of subdivision (a) of Section 12944 of the  
32 Government Code.

33 (d) The American Board of Dental Examiners, Inc. shall pay  
34 all reasonable costs and expenses the board incurs for the purposes  
35 of implementing this section.

36 *(e) The American Board of Dental Examiners, Inc. examination*  
37 *may only be accepted for licensure by a candidate after it is*  
38 *determined that the examination has met the requirements of this*  
39 *section. Examinations taken prior to that date may not be used for*  
40 *licensure.*

1 SEC. 3. Section 1632.7 is added to the Business and Professions  
2 Code, to read:

3 1632.7. The Department of Finance may accept funds pursuant  
4 to Sections 11005.1 and 16302 of the Government Code for the  
5 purposes of reviewing and ~~implementing~~ *analyzing* the examination  
6 developed by the American Board of Dental Examiners, Inc., as  
7 described in ~~paragraph (2) of subdivision (e) of Section 1632.~~  
8 *Section 1632.55.*

O



**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
August 2016 BOARD MEETING**

---

---

<b>BILL NUMBER:</b>	Assembly Bill 2485		
<b>AUTHOR:</b>	Assembly Member Miguel Santiago	<b>SPONSOR:</b>	California Dental Association
<b>VERSION:</b>	Amended in Assembly 05/27/2016	<b>INTRODUCED:</b>	2/19/2016
<b>BILL STATUS:</b>	06/28/2016-Do pass and Re-referred to Com. On APPR.	<b>BILL LOCATION:</b>	Senate Appropriations
<b>SUBJECT:</b>	Dental Corps Loan Repayment Program	<b>RELATED BILLS:</b>	

**SUMMARY**

Existing law establishes the Dental Corps Loan Repayment Program of 2002 within the Dental Board of California. Existing law creates the Dentally Underserved Account within the State Dentistry Fund. The program assists dentists who practice in an underserved area with loan repayment pursuant to an agreement between the board and the dentist, as specified.

This bill in amended form would propose the following:

- Allows those currently eligible for graduation from a pre-doctoral or post-doctoral dental education program and who meets all criteria for licensure to apply;
- Requests disclosure of any and all loan obligations;
- Requires applicant to sign an agreement to maintain qualified employment for 36 months continuously with an eligible practice setting;
- Requires applicant to provide annual progress report including the information as specified;
- Provides for priority consideration as specified for candidate selection;
- Specifies practice setting;
- Specifies full-time basis
- Provides the Board with authority to terminate for cause as specified;
- Provides that the Board grant \$35,000 for loan repayment annually for three years not to exceed \$105,000 or total amount of the loan, whichever is the lesser amount; and
- Disburses funds within 30 days from execution of a program agreement between the Board and the qualified lender selected by the recipient and subsequently requires the disbursement of year two and year three funds within 30 days of months 13 and 25 of the recipient's participation in the program.

**ANALYSIS**

This bill in amended form essentially keeps the authority to implement this loan repayment program with the Dental Board of California while adjusting the language to provide for a broader applicant pool while maintaining the intent of the legislation when the loan repayment program was established.

The fiscal impact as a result of implementing this bill is minor and absorbable as this program is currently being administered by the Dental Board. There will be the need to update and amend regulations in order to comply with the proposed statutory language.

### **REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

### **BOARD POSITION**

The Board took a "WATCH" position during the March 2016 Board meeting. The Board may consider taking any one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

Staff recommends that the Board take a "Support if Amended" position on this bill. The following should be amended:

- Delete the legislative intent language in Section 1.
- Delete the "five year term" from Business and Professions Code Section 1972 (a)
- Delete Subsections (g) and (h) from Code Section 1972 and keep original language from existing statute under Subsections (e) and (g) of Section 1972.

AMENDED IN ASSEMBLY MAY 27, 2016  
AMENDED IN ASSEMBLY APRIL 11, 2016  
AMENDED IN ASSEMBLY MARCH 30, 2016  
CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 2485**

---

---

**Introduced by Assembly Member Santiago**

February 19, 2016

---

---

~~An act to repeal Article 9.5 (commencing with Section 1970) of Chapter 4 of Division 2 of the Business and Professions Code, and to amend Section 128345 of, and to add Article 7 (commencing with Section 128587) to Chapter 5 of Part 3 of Division 107 of, the Health and Safety Code, relating to dentistry. An act to amend Sections 1970, 1970.5, and 1973 of, to amend and repeal Section 1976 of, and to repeal and add Sections 1971, 1972, and 1975 of, the Business and Professions Code, relating to dentistry.~~

LEGISLATIVE COUNSEL'S DIGEST

AB 2485, as amended, Santiago. Dental Corps Loan Repayment Program.

*Under the Dental Practice Act, the Dental Board of California is responsible for the licensure and regulation of dentists. Existing law establishes the Dental Corps Loan Repayment Program of 2002 to assist dentists who practice in an underserved area with loan repayment pursuant to an agreement between the board and the dentist, as specified. Existing law governs eligibility, application, selection, placement, and repayment for the program, and authorizes the board to adopt standards to implement the program relating to eligibility, placement, and termination. Existing law creates the Dentally*

*Underserved Account within the State Dentistry Fund and moneys in the account are continuously appropriated for purposes of the program.*

*This bill would require that the program be known as the California Dental Corps Loan Repayment Program and would revise program provisions regarding eligibility, application, selection, placement, and repayment. The bill would establish specific grounds for termination and would authorize the board to require the repayment of loans or grants in the case of termination. Among other new program requirements, applicants would be required to sign the agreement with the board under penalty of perjury and to provide annual progress reports, signed under penalty of perjury by both the applicant and employer, thereby imposing a state-mandated local program by creating new crimes.*

*The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.*

*This bill would provide that no reimbursement is required by this act for a specified reason.*

~~Existing law establishes the Dental Corps Loan Repayment Program of 2002 within the Dental Board of California. Existing law creates the Dentally Underserved Account within the State Dentistry Fund. The program assists dentists who practice in an underserved area with loan repayment pursuant to an agreement between the board and the dentist, as specified.~~

~~This bill would repeal those provisions and instead transfer the authority to implement the program to the Health Professions Education Foundation within the Office of Statewide Health Planning and Development and would rename the account the Dental Corps Loan Repayment Account. The bill would make funds in the account available, upon appropriation by the Legislature, for purposes of the program. The bill would require the foundation to submit a report to the Dental Board of California and the Legislature by July 1, 2018. The bill would make related findings and declarations.~~

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: ~~no~~ yes.

*The people of the State of California do enact as follows:*

1     *SECTION 1. It is the intent of the Legislature that the changes*  
2 *made by this act are comprehensive, and that regulations do not*  
3 *need to be promulgated by the Dental Board of California to*  
4 *implement the changes made by this act.*

5     *SEC. 2. Section 1970 of the Business and Professions Code is*  
6 *amended to read:*

7     1970. There is hereby established in the Dental Board of  
8 California the Dental Corps Loan Repayment Program of 2002,  
9 which shall become operative on January 1, 2003. This program  
10 shall be known and may be cited as the California Dental Corps  
11 Loan Repayment ~~Program of 2002.~~ *Program.*

12     *SEC. 3. Section 1970.5 of the Business and Professions Code*  
13 *is amended to read:*

14     1970.5. It is the intent of the this article that the Dental Board  
15 of California, ~~in consultation with the Office of Statewide Health~~  
16 ~~Planning and Development, the dental community, including ethnic~~  
17 ~~representatives, dental schools, health advocates representing ethnic~~  
18 ~~communities, primary care clinics, public hospitals and health~~  
19 ~~systems, statewide agencies administering state and federally~~  
20 ~~funded programs targeting underserved communities, and members~~  
21 ~~of the public with health care issue-area expertise shall develop~~  
22 ~~and California implement the California Dental Corps Loan~~  
23 ~~Repayment Program of 2002.~~ *Program.*

24     *SEC. 4. Section 1971 of the Business and Professions Code is*  
25 *repealed.*

26     1971. For the purposes of this article, the following terms have  
27 the following meanings:

- 28     (a) ~~“Board” means the Dental Board of California.~~
- 29     (b) ~~“Office” means the Office of Statewide Health Planning and~~  
30 ~~Development.~~
- 31     (c) ~~“Program” means the California Dental Corps Loan~~  
32 ~~Repayment Program.~~
- 33     (d) ~~“Dentally underserved area” means a geographic area eligible~~  
34 ~~to be designated as having a shortage of dental professionals~~  
35 ~~pursuant to Part I of Appendix B to Part 5 of Chapter 1 of Title 42~~  
36 ~~of the Code of Federal Regulations or an area of the state where~~  
37 ~~unmet priority needs for dentists exist as determined by the~~

1 California Healthcare Workforce Policy Commission pursuant to  
2 Section 128224 of the Health and Safety Code.

3 (e) “Dentally underserved population” means persons without  
4 dental insurance and persons eligible for the Denti-Cal and Healthy  
5 Families Programs who are population groups described as having  
6 a shortage of dental care professionals in Part I of Appendix B to  
7 Part 5 of Chapter 1 of Title 42 of the Code of Federal Regulations.

8 (f) “Practice setting” means either of the following:

9 (1) A community clinic, as defined in subdivision (a) of Section  
10 1204 and subdivision (c) of Section 1206 of the Health and Safety  
11 Code, a clinic owned or operated by a public hospital and health  
12 system, or a clinic owned and operated by a hospital that maintains  
13 the primary contract with a county government to fulfill the  
14 county’s role pursuant to Section 17000 of the Welfare and  
15 Institutions Code, which is located in a dentally underserved area  
16 and at least 50 percent of whose patients are from a dentally  
17 underserved population.

18 (2) A dental practice or dental corporation, as defined in Section  
19 1800 of this code, located in a dentally underserved area and at  
20 least 50 percent of whose patients are from a dentally underserved  
21 population.

22 (g) “Medi-Cal threshold languages” means primary languages  
23 spoken by limited-English-proficient (LEP) population groups  
24 meeting a numeric threshold of 3,000, eligible LEP Medi-Cal  
25 beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP  
26 beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal  
27 beneficiaries residing in two contiguous ZIP Codes.

28 (h) “Fund” means the State Dentistry Fund.

29 (i) “Account” means the Dentally Underserved Account which  
30 is contained within the fund.

31 *SEC. 5. Section 1971 is added to the Business and Professions*  
32 *Code, to read:*

33 *1971. As used in this article:*

34 (a) “Account” means the Dentally Underserved Account  
35 established in Section 1973, which is contained within the fund.

36 (b) “Board” means the Dental Board of California.

37 (c) “Dentally underserved area” means a geographic area  
38 eligible to be designated as having a shortage of dental  
39 professionals pursuant to Part I of Appendix B to Part 5 of Chapter  
40 1 of Title 42 of the Code of Federal Regulations or an area of the

1 *state in which unmet priority needs for dentists exist as determined*  
2 *by the California Healthcare Workforce Policy Commission*  
3 *pursuant to Section 128224 of the Health and Safety Code.*

4 (d) *“Dentally underserved population” means persons without*  
5 *dental insurance and persons eligible for Denti-Cal who are*  
6 *population groups described as having a shortage of dental care*  
7 *professionals in Part I of Appendix B to Part 5 of Chapter 1 of*  
8 *Title 42 of the Code of Federal Regulations.*

9 (e) *“Fund” means the State Dentistry Fund.*

10 (f) *“Medi-Cal threshold languages” means primary languages*  
11 *spoken by limited-English-proficient (LEP) population groups*  
12 *meeting a numeric threshold of 3,000 eligible LEP Medi-Cal*  
13 *beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP*  
14 *beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal*  
15 *beneficiaries residing in two contiguous ZIP Codes.*

16 (g) *“Office” means the Office of Statewide Health Planning*  
17 *and Development.*

18 (h) *“Program” means the California Dental Corps Loan*  
19 *Repayment Program.*

20 (i) *“Practice setting” means either of the following:*

21 (1) *A community clinic, as defined in subdivision (a) of Section*  
22 *1204 and subdivision (c) of Section 1206 of the Health and Safety*  
23 *Code, a clinic owned or operated by a public hospital and health*  
24 *system, or a clinic owned and operated by a hospital that maintains*  
25 *the primary contract with a county government to fulfill the*  
26 *county’s role pursuant to Section 17000 of the Welfare and*  
27 *Institutions Code, which is located in a dentally underserved area*  
28 *and at least 50 percent of whose patients are from a dentally*  
29 *underserved population.*

30 (2) *A dental practice or dental corporation, as defined in Section*  
31 *1800, located in a dentally underserved area and at least 50*  
32 *percent of whose patients are from a dentally underserved*  
33 *population.*

34 *SEC. 6. Section 1972 of the Business and Professions Code is*  
35 *repealed.*

36 ~~1972. (a) Program applicants shall possess a current valid~~  
37 ~~license to practice dentistry in this state issued by the board~~  
38 ~~pursuant to Section 1626.~~

39 ~~(b) The board, in accordance with Section 1970.5, shall develop~~  
40 ~~the guidelines for selection and placement of applicants.~~

- 1     ~~(1) Guidelines shall provide priority consideration to applicants~~
- 2     ~~who are best suited to meet the cultural and linguistic needs and~~
- 3     ~~demands of dentally underserved populations and that meet one~~
- 4     ~~or more of the following criteria:~~
- 5         ~~(A) Speak a Medi-Cal threshold language.~~
- 6         ~~(B) Come from an economically disadvantaged background.~~
- 7         ~~(C) Have received significant training in cultural and~~
- 8     ~~linguistically appropriate service delivery.~~
- 9         ~~(D) Have worked with dentally underserved communities for~~
- 10     ~~at least three years.~~
- 11         ~~(E) Recently received a license to practice dentistry.~~
- 12     ~~(2) The guidelines shall include a process for determining the~~
- 13     ~~needs for dentist services identified by the practice setting. At a~~
- 14     ~~minimum, the practice setting shall meet the following criteria:~~
- 15         ~~(A) The practice setting shall be located in a dentally~~
- 16     ~~underserved area.~~
- 17         ~~(B) The practice setting shall ensure that the program participant~~
- 18     ~~serves a patient population that consists of at least 50 percent~~
- 19     ~~dentally underserved populations.~~
- 20     ~~(3) Guidelines shall seek to place the most qualified applicants~~
- 21     ~~under this section in the areas with the greatest need.~~
- 22     ~~(4) Guidelines shall include a factor ensuring geographic~~
- 23     ~~distribution of placements.~~
- 24         ~~(e) Program applicants shall be working in or have a signed~~
- 25     ~~agreement with an eligible practice setting. The program participant~~
- 26     ~~shall have full-time status. Full-time status shall be defined by the~~
- 27     ~~board, and the board may establish exemptions to this requirement~~
- 28     ~~on a case-by-case basis.~~
- 29         ~~(d) Program participants shall commit to a minimum of three~~
- 30     ~~years of service in a dentally underserved area. The board, in~~
- 31     ~~accordance with Section 1970.5, shall develop the process for~~
- 32     ~~determining the maximum length of an absence and the process~~
- 33     ~~for reinstatement. Loan repayment shall be deferred until the dentist~~
- 34     ~~is back to full-time status.~~
- 35         ~~(e) The board, in accordance with Section 1970.5, shall develop~~
- 36     ~~the process if a dentist is not able to complete his or her three-year~~
- 37     ~~obligation.~~
- 38         ~~(f) The board, in accordance with Section 1970.5, shall develop~~
- 39     ~~a process for outreach to potentially eligible applicants.~~



1 ~~(g) The board may adopt any other standards of eligibility,~~  
2 ~~placement and termination appropriate to achieve the aim of~~  
3 ~~providing competent dental services in these approved practice~~  
4 ~~settings.~~

5 *SEC. 7. Section 1972 is added to the Business and Professions*  
6 *Code, to read:*

7 *1972. (a) (1) A program applicant shall possess a current*  
8 *valid license to practice dentistry in this state issued by the board*  
9 *pursuant to Section 1626 within the five years immediately prior*  
10 *to application for the program, or be currently eligible for*  
11 *graduation from a predoctoral or postdoctoral dental education*  
12 *program approved by the Commission on Dental Accreditation or*  
13 *the board and meet all criteria for licensure, subject to successful*  
14 *completion of applicable education and examination requirements.*

15 *(2) An applicant shall submit documentation detailing current*  
16 *loan obligations from any government or commercial lender*  
17 *obtained for purposes of financing tuition or fees at a dental school*  
18 *approved by the Commission on Dental Accreditation or the board.*  
19 *Documentation shall contain the applicant's account number and*  
20 *the lender's contact information, as well as current balance owing*  
21 *and monthly installment plan details, if applicable.*

22 *(3) An application shall include disclosure of any and all*  
23 *obligations for which the applicant has defaulted or been subject*  
24 *to a judgment lien within the last 10 years, and explanations for*  
25 *each default or judgment lien disclosed.*

26 *(4) An applicant, if selected to receive a repayment grant, shall*  
27 *sign an agreement with the board, under penalty of perjury, to*  
28 *maintain qualified employment for 36 months continuously, and*  
29 *that the qualified employment meets or will meet the minimum*  
30 *requirements of the program regarding practice setting, clinical*  
31 *hours worked, and population served.*

32 *(5) An applicant shall also agree to provide an annual progress*  
33 *report, signed under penalty of perjury by both the applicant and*  
34 *employer or employer's designee. A progress report shall verify*  
35 *the practice setting's qualified status, clinical hours worked by*  
36 *the applicant, number of patients treated, specific treatment*  
37 *rendered and its value, and patient's payer source.*

38 *(b) The board, in selecting a participant for the program, shall*  
39 *give priority consideration to an applicant who is best suited to*  
40 *meet the cultural and linguistic needs and demands of dentally*

- 1 *underserved populations by demonstrating experience in one or*  
2 *more of the following areas:*
- 3 *(1) Speaks one or more Medi-Cal threshold languages.*
  - 4 *(2) Comes from an economically disadvantaged background*  
5 *with economic, social, or other circumstances.*
  - 6 *(3) Has worked in a health field in an underserved area or with*  
7 *an underserved population.*
  - 8 *(4) Is a dentist specialist recognized by the American Dental*  
9 *Association or has met all eligibility requirements to graduate*  
10 *from a dental specialty residency program approved by the*  
11 *Commission on Dental Accreditation.*
  - 12 *(5) Has completed an extramural program or rotation during*  
13 *dental school or postgraduate education in which the applicant*  
14 *provided services to a population that speaks any Medi-Cal*  
15 *threshold language.*
- 16 *(c) The practice setting shall meet one or both of the following*  
17 *criteria:*
- 18 *(1) The practice setting shall be located in a dentally*  
19 *underserved area.*
  - 20 *(2) The practice setting shall ensure that the program*  
21 *participant serves a patient population that consists of at least 50*  
22 *percent dentally underserved populations.*
- 23 *(d) A program applicant shall be working in, or have a signed*  
24 *agreement for future employment with, an eligible practice setting.*  
25 *The program participant shall be employed on a full-time basis.*  
26 *“Full-time basis” means 30 hours of clinical hands-on care per*  
27 *week, for no less than 45 weeks per year, except as provided for*  
28 *during customary holidays, personal or family illness, and vacation*  
29 *time as described in a separate employment agreement between*  
30 *the recipient and the practice setting. Upon 30-day notice to the*  
31 *board, the board shall grant an extended leave of absence period*  
32 *for serious illness, pregnancy, or other natural cause. The board*  
33 *may establish other exemptions to the minimum time requirements*  
34 *of this subdivision on a case-by-case basis.*
- 35 *(e) A program participant shall commit to a minimum of three*  
36 *years of service in one or more eligible practice settings. Loan*  
37 *repayment shall be deferred until the dentist is employed on a*  
38 *full-time basis.*

1 (f) *The board may coordinate with local and statewide trade*  
2 *and professional dental organizations, as well as educational*  
3 *institutions, for outreach to potentially eligible applicants.*

4 (g) *The board may terminate the applicant's participation in*  
5 *the program for cause. Cause for termination shall include the*  
6 *following:*

7 (1) *Recipient's termination of full-time, qualified employment.*

8 (2) *Recipient's failure to maintain his or her professional license*  
9 *in good standing.*

10 (3) *Recipient's failure to comply with any other term or*  
11 *condition of this article.*

12 (h) *If the board terminates a recipient's participation for cause*  
13 *at any time during the 36-month period of the program, the board*  
14 *may require the recipient to repay the total amount of loans or*  
15 *grants disbursed in their name plus 10 percent interest within a*  
16 *maximum period of seven years.*

17 *SEC. 8. Section 1973 of the Business and Professions Code is*  
18 *amended to read:*

19 1973. (a) *The Dentally Underserved Account is hereby created*  
20 *in the State Dentistry Fund.*

21 (b) *The sum of three million dollars (\$3,000,000) is hereby*  
22 *authorized to be expended from the State Dentistry Fund on this*  
23 *program. These moneys are appropriated as follows:*

24 (1) *One million dollars (\$1,000,000) shall be transferred from*  
25 *the State Dentistry Fund fund to the Dentally Underserved Account*  
26 *account on July 1, 2003. Of this amount, sixty-five thousand dollars*  
27 *(\$65,000) shall be used by the Dental Board of California board*  
28 *in the 2003-04 fiscal year for operating expenses necessary to*  
29 *manage this program.*

30 (2) *One million dollars (\$1,000,000) shall be transferred from*  
31 *the State Dentistry Fund fund to the Dentally Underserved Account*  
32 *account on July 1, 2004. Of this amount, sixty-five thousand dollars*  
33 *(\$65,000) shall be used by the Dental Board of California board*  
34 *in the 2004-05 fiscal year for operating expenses necessary to*  
35 *manage this program.*

36 (3) *One million dollars (\$1,000,000) shall be transferred from*  
37 *the State Dentistry Fund fund to the Dentally Underserved Account*  
38 *account on July 1, 2005. Of this amount, sixty-five thousand dollars*  
39 *(\$65,000) shall be used by the Dental Board of California board*

1 in the 2005–06 fiscal year for operating expenses necessary to  
2 manage this program.

3 (c) Funds placed into the ~~Dentally Underserved Account~~ *account*  
4 shall be used by the board to repay the loans per agreements made  
5 with dentists.

6 (1) Funds paid out for loan repayment may have a funding match  
7 from foundation or other private sources.

8 (2) Loan repayments ~~may~~ *shall* not exceed one hundred five  
9 thousand dollars (\$105,000) per individual licensed dentist.

10 (3) Loan repayments ~~may~~ *shall* not exceed the amount of the  
11 educational loans incurred by the dentist applicant.

12 (d) Notwithstanding Section 11005 of the Government Code,  
13 the board may seek and receive matching funds from foundations  
14 and private sources to be placed into the ~~Dentally Underserved~~  
15 ~~Account.~~ *account*. The board also may contract with an exempt  
16 foundation for the receipt of matching funds to be transferred to  
17 the ~~Dentally Underserved Account~~ *account* for use by this program.

18 (e) Funds in the ~~Dentally Underserved Account~~ *account*  
19 appropriated in subdivision (b) or received pursuant to subdivision  
20 (d) are continuously appropriated for the repayment of loans per  
21 agreements made between the board and the dentists.

22 (f) On or after July 1, 2010, the board shall extend the ~~California~~  
23 ~~Dental Corps Loan Repayment Program of 2002~~ *program* and  
24 distribute the money remaining in the account until all the moneys  
25 in the account are expended. ~~Regulations that were adopted by the~~  
26 ~~board for the purposes of the program shall apply.~~

27 *SEC. 9. Section 1975 of the Business and Professions Code is*  
28 *repealed.*

29 ~~1975.~~ The terms of loan repayment granted under this article  
30 shall be as follows:

31 (a) ~~After a program participant has completed one year of~~  
32 ~~providing services as a dentist in a dentally underserved area, the~~  
33 ~~board shall provide up to twenty-five thousand dollars (\$25,000)~~  
34 ~~for loan repayment.~~

35 (b) ~~After a program participant has completed two consecutive~~  
36 ~~years of providing services as a dentist in a dentally underserved~~  
37 ~~area, the board shall provide up to an additional thirty-five thousand~~  
38 ~~dollars (\$35,000) of loan repayment, for a total loan repayment of~~  
39 ~~up to sixty thousand dollars (\$60,000).~~

1 (e) ~~After a program participant has completed three consecutive~~  
2 ~~years of providing services as a dentist in a dentally underserved~~  
3 ~~area, the board shall provide up to a maximum of an additional~~  
4 ~~forty-five thousand dollars (\$45,000) of loan repayment, for a total~~  
5 ~~loan repayment of up to one hundred five thousand dollars~~  
6 ~~(\$105,000).~~

7 *SEC. 10. Section 1975 is added to the Business and Professions*  
8 *Code, to read:*

9 *1975. The terms of loan repayment granted under this article*  
10 *shall be as follows:*

11 *(a) After a program participant has been selected by the board*  
12 *to provide services as a dentist in the program, the board shall*  
13 *provide thirty-five thousand dollars (\$35,000) for loan repayment*  
14 *annually, for three years, to reach a total of one hundred five*  
15 *thousand dollars (\$105,000), or the total amount of the loan,*  
16 *whichever is the lesser amount.*

17 *(b) The initial disbursement of funds shall be made within 30*  
18 *days from execution of a program agreement between the board*  
19 *and the recipient directly from the board to the qualified lender*  
20 *selected by the recipient, to be credited to the recipient's account.*

21 *(c) Subsequent disbursements in sums equal to the initial*  
22 *disbursement, but not equaling more than the total amount owed*  
23 *by the recipient, shall be made within 30 days of months 13 and*  
24 *25 of the recipient's participation in the program.*

25 *SEC. 11. Section 1976 of the Business and Professions Code*  
26 *is amended to read:*

27 ~~1976. (a) On January 1, 2003, applications from dentists for~~  
28 ~~program participation may be submitted.~~

29 ~~(b)~~

30 *1976. (a) The board shall report to the Legislature, ~~no later~~*  
31 *than ~~October 1, 2004,~~ during its sunset review period, the*  
32 *experience of the program since its inception, an evaluation of its*  
33 *effectiveness in improving access to dental care for underserved*  
34 *populations, and recommendations for maintaining or expanding*  
35 *its operation. The report to the Legislature shall also include the*  
36 *following:*

37 (1) The number of the program participants.

38 (2) The practice locations.

39 (3) The amount expended for the program.

1 (4) The information on annual performance reviews progress  
2 reports by practice settings and program participants.

3 ~~(e) The board may promulgate emergency regulations to  
4 implement the program.~~

5 (b) *The report to the Legislature pursuant to subdivision (a)*  
6 *shall be submitted in compliance with Section 9795 of the*  
7 *Government Code.*

8 (c) *Pursuant to Section 10231.5 of the Government Code, this*  
9 *section is repealed on January, 1, 2021.*

10 *SEC. 12. No reimbursement is required by this act pursuant*  
11 *to Section 6 of Article XIII B of the California Constitution because*  
12 *the only costs that may be incurred by a local agency or school*  
13 *district will be incurred because this act creates a new crime or*  
14 *infraction, eliminates a crime or infraction, or changes the penalty*  
15 *for a crime or infraction, within the meaning of Section 17556 of*  
16 *the Government Code, or changes the definition of a crime within*  
17 *the meaning of Section 6 of Article XIII B of the California*  
18 *Constitution.*

19 ~~SECTION 1. The Legislature hereby finds and declares all of  
20 the following:~~

21 ~~(a) An adequate supply of dentists is critical to assuring the  
22 health and well-being of California residents, particularly those  
23 who live in medically underserved areas.~~

24 ~~(b) It is in the best interest of the state and its residents that  
25 dental services be provided throughout the state in a manner that  
26 can be effectively accessed by the residents of all communities.~~

27 ~~(c) The Dental Board of California has established the California  
28 Dental Corps Loan Repayment Program of 2002 to improve access  
29 to dental care for underserved populations.~~

30 ~~(d) The Health Professions Education Foundation, established  
31 in 1987, is the state's only nonprofit foundation statutorily created  
32 to encourage persons from underserved communities to become  
33 health professionals and increase access to health providers in  
34 medically underserved areas.~~

35 ~~(e) The foundation improves access to health care in underserved  
36 areas by providing scholarships, loan repayments, and programs  
37 to health professional students and graduates who are dedicated  
38 to providing direct patient care in those areas.~~

39 ~~(f) It is the intent of the Legislature to move the California  
40 Dental Corps Loan Repayment Program of 2002 from the Dental~~

1 Board of California to the Health Professions Education Foundation  
2 within the Office of Statewide Health Planning and Development.

3 ~~SEC. 2. Article 9.5 (commencing with Section 1970) of Chapter~~  
4 ~~4 of Division 2 of the Business and Professions Code is repealed.~~

5 ~~SEC. 3. Section 128345 of the Health and Safety Code is~~  
6 ~~amended to read:~~

7 ~~128345. The Health Professions Education Foundation may~~  
8 ~~do any of the following:~~

9 ~~(a) Solicit and receive funds from business, industry,~~  
10 ~~foundations, and other private or public sources for the purpose~~  
11 ~~of providing financial assistance in the form of scholarships or~~  
12 ~~loans to African-American students, Native American students,~~  
13 ~~Hispanic-American students, and other students from~~  
14 ~~underrepresented groups. These funds shall be expended by the~~  
15 ~~office after transfer to the Health Professions Education Fund,~~  
16 ~~created pursuant to Section 128355.~~

17 ~~(b) Recommend to the director the disbursement of private~~  
18 ~~sector moneys deposited in the Health Professions Education Fund~~  
19 ~~to students from underrepresented groups accepted to or enrolled~~  
20 ~~in schools of medicine, dentistry, nursing, or other health~~  
21 ~~professions in the form of loans or scholarships.~~

22 ~~(c) Recommend to the director a standard contractual agreement~~  
23 ~~to be signed by the director and any participating student, that~~  
24 ~~would require a period of obligated professional service in the~~  
25 ~~areas in California designated by the commission as deficient in~~  
26 ~~primary care services. The agreement shall include a clause~~  
27 ~~entitling the state to recover the funds awarded plus the maximum~~  
28 ~~allowable interest for failure to begin or complete the service~~  
29 ~~obligation.~~

30 ~~(d) Develop criteria for evaluating the likelihood that applicants~~  
31 ~~for scholarships or loans would remain to practice their profession~~  
32 ~~in designated areas deficient in primary care services.~~

33 ~~(e) Develop application forms, which shall be disseminated to~~  
34 ~~students from underrepresented groups interested in applying for~~  
35 ~~scholarships or loans.~~

36 ~~(f) Encourage private sector institutions, including hospitals,~~  
37 ~~community clinics, and other health agencies to identify and~~  
38 ~~provide educational experiences to students from underrepresented~~  
39 ~~groups who are potential applicants to schools of medicine,~~  
40 ~~dentistry, nursing, or other health professions.~~

1 (g) Prepare and submit an annual report to the office  
2 documenting the amount of money solicited from the private sector,  
3 the number of scholarships and loans awarded, the enrollment  
4 levels of students from underrepresented groups in schools of  
5 medicine, dentistry, nursing, and other health professions, and the  
6 projected need for scholarships and loans in the future.

7 (h) Recommend to the director that a portion of the funds  
8 solicited from the private sector be used for the administrative  
9 requirements of the foundation.

10 (i) Implement the Steven M. Thompson Physician Corps Loan  
11 Repayment Program and the Volunteer Physician Program, as  
12 provided under Article 5 (commencing with Section 128550).

13 (j) Implement the California Dental Corps Loan Repayment  
14 Program, as provided under Article 7 (commencing with Section  
15 128587) of Chapter 5 of Part 3 of Division 107.

16 SEC. 4. Article 7 (commencing with Section 128587) is added  
17 to Chapter 5 of Part 3 of Division 107 of the Health and Safety  
18 Code, to read:

19  
20 Article 7. California Dental Corps Loan Repayment Program

21  
22 128587. (a) There is hereby established the California Dental  
23 Corps Loan Repayment Program within the Health Professions  
24 Education Foundation within the Office of Statewide Health  
25 Planning and Development.

26 (b) It is the intent of the Legislature in enacting this article that  
27 the foundation and the office provide the ongoing program  
28 management for the program.

29 128587.2. For purposes of this article, the following definitions  
30 apply:

31 (a) "Account" means the Dentally Underserved Account, which  
32 is contained within the fund.

33 (b) "Board" means the Dental Board of California.

34 (c) "Dentally underserved area" means a geographic area eligible  
35 to be designated as having a shortage of dental professionals  
36 pursuant to Part I of Appendix B to Part 5 of Chapter 1 of Title 42  
37 of the Code of Federal Regulations or an area of the state in which  
38 unmet priority needs for dentists exist as determined by the  
39 California Healthcare Workforce Policy Commission pursuant to  
40 Section 128224.



1 (d) “Dentally underserved population” means persons without  
2 dental insurance and persons eligible for Denti-Cal who are  
3 population groups described as having a shortage of dental care  
4 professionals in Part I of Appendix B to Part 5 of Chapter 1 of  
5 Title 42 of the Code of Federal Regulations.

6 (e) “Fund” means the State Dentistry Fund.

7 (f) “Medi-Cal threshold languages” means primary languages  
8 spoken by limited-English-proficient (LEP) population groups  
9 meeting a numeric threshold of 3,000, eligible LEP Medi-Cal  
10 beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP  
11 beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal  
12 beneficiaries residing in two contiguous ZIP Codes.

13 (g) “Office” means the Office of Statewide Health Planning and  
14 Development.

15 (h) “Program” means the California Dental Corps Loan  
16 Repayment Program.

17 (i) “Practice setting” means either of the following:

18 (1) A community clinic, as defined in subdivision (a) of Section  
19 1204 and subdivision (c) of Section 1206, a clinic owned or  
20 operated by a public hospital and health system, or a clinic owned  
21 and operated by a hospital that maintains the primary contract with  
22 a county government to fulfill the county’s role pursuant to Section  
23 17000 of the Welfare and Institutions Code, which is located in a  
24 dentally underserved area.

25 (2) A dental practice or dental corporation, as defined in Section  
26 1800 of the Business and Professions Code, located in a dentally  
27 underserved area or at least 50 percent of whose patients are from  
28 a dentally underserved population.

29 128587.4. (a) A program applicant shall possess a current  
30 valid license to practice dentistry in this state issued by the board  
31 pursuant to Section 1626 of the Business and Professions Code,  
32 or be currently eligible for graduation from a pre- or postdoctoral  
33 dental education program approved by the board or the  
34 Commission on Dental Accreditation and meet all criteria for  
35 licensure subject to successful completion of applicable education  
36 and examination requirements.

37 (b) The foundation shall develop the guidelines for selection  
38 and placement of applicants:

39 (1) The guidelines shall provide priority consideration to  
40 applicants who are best suited to meet the cultural and linguistic

- 1 needs and demands of dentally underserved populations and who
- 2 meet one or more of the following criteria:
- 3 (A) Speak a Medi-Cal threshold language.
- 4 (B) Come from an economically disadvantaged background.
- 5 (C) Have received significant training in cultural and
- 6 linguistically appropriate service delivery.
- 7 (D) Have worked in a health field in an underserved area or
- 8 with an underserved population.
- 9 (E) Recently received a license to practice dentistry.
- 10 (F) Have received an offer for employment from a practice
- 11 setting.
- 12 (2) The guidelines shall include a process for determining the
- 13 needs for dental services identified by the practice setting. At a
- 14 minimum, the practice setting shall be located in a dentally
- 15 underserved area.
- 16 (3) The guidelines shall seek to place the most qualified
- 17 applicants under this section in the areas with the greatest need.
- 18 (e) A program applicant shall be working in, or have a signed
- 19 agreement with, an eligible practice setting. The program
- 20 participant shall be employed on a full-time basis. Full-time basis
- 21 shall be defined by the foundation, and the foundation may
- 22 establish exemptions to this requirement on a case-by-case basis.
- 23 (d) A program participant shall commit to a minimum of three
- 24 years of service in one or more practice settings. The foundation
- 25 shall develop the process for determining the maximum length of
- 26 an absence and the process for reinstatement of a participant. Loan
- 27 repayment shall be deferred until the dentist is employed on a
- 28 full-time basis.
- 29 (e) The foundation shall develop a process to use if a dentist is
- 30 not able to complete his or her three-year obligation.
- 31 (f) The foundation shall develop a process for outreach to
- 32 potentially eligible applicants.
- 33 (g) The foundation may adopt any other standards of eligibility,
- 34 placement, and termination appropriate to achieve the aim of
- 35 providing competent dental services in these approved practice
- 36 settings.
- 37 128587.6 (a) The Dentally Underserved Account, formerly
- 38 established pursuant to subdivision (a) of Section 1973 of the
- 39 Business and Professions Code, in the State Dentistry Fund in the
- 40 Professions and Vocations Fund in the State Treasury is hereby

1 ~~renamed the Dental Corps Loan Repayment Account and~~  
2 ~~established by this section in the State Dentistry Fund.~~

3 ~~(b) (1) Funds placed in the account shall be available upon~~  
4 ~~appropriation by the Legislature.~~

5 ~~(2) Funds in the account shall be used by the foundation to repay~~  
6 ~~the loans per agreements made with dentists.~~

7 ~~(3) Funds paid out for loan repayment may have a funding match~~  
8 ~~from foundations or other private sources.~~

9 ~~(4) Loan repayments shall not exceed a total of one hundred~~  
10 ~~five thousand dollars (\$105,000) per individual licensed dentist.~~

11 ~~(5) Notwithstanding Section 11005 of the Government Code,~~  
12 ~~the foundation may seek and receive funds from foundations and~~  
13 ~~private sources to be placed into the account.~~

14 ~~128587.8. The terms of loan repayment granted under this~~  
15 ~~article shall be as follows:~~

16 ~~(a) After a program participant has completed six months of~~  
17 ~~providing services on a full-time basis in a practice setting, the~~  
18 ~~foundation shall provide up to thirty-five thousand dollars~~  
19 ~~(\$35,000) for loan repayment.~~

20 ~~(b) After a program participant has completed 18 consecutive~~  
21 ~~months of providing services on a full-time basis in a practice~~  
22 ~~setting, the foundation shall provide up to an additional thirty-five~~  
23 ~~thousand dollars (\$35,000) of loan repayment, for a total loan~~  
24 ~~repayment of up to seventy thousand dollars (\$70,000).~~

25 ~~(c) After a program participant has completed 30 consecutive~~  
26 ~~months of providing services on a full-time basis in a practice~~  
27 ~~setting, the foundation shall provide up to a maximum of thirty-five~~  
28 ~~thousand dollars (\$35,000) of loan repayment, for a total loan~~  
29 ~~repayment of up to one hundred five thousand dollars (\$105,000);~~  
30 ~~but not to exceed the total outstanding amount of the loan.~~

31 ~~128587.9. (a) On or before July 1, 2018, the foundation shall~~  
32 ~~submit a report to the board and the Legislature regarding the~~  
33 ~~experience of the program, an evaluation of its effectiveness in~~  
34 ~~improving access to dental care for underserved populations, and~~  
35 ~~recommendations for maintaining or expanding its operation,~~  
36 ~~including, but not limited to, all of the following:~~

37 ~~(1) Number of program participants.~~

38 ~~(2) Practice locations.~~

39 ~~(3) Amount of funds expended.~~

1     ~~(4) The information on annual performance reviews by practice~~  
2     ~~settings and program participants.~~

3     ~~(b) The report to the Legislature pursuant to subdivision (a)~~  
4     ~~shall be submitted in compliance with Section 9795 of the~~  
5     ~~Government Code.~~

6     ~~(e) Pursuant to Section 10231.5 of the Government Code, this~~  
7     ~~section is repealed on July 1, 2022.~~

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
AUGUST 2016 BOARD MEETING**

---

---

<b>BILL NUMBER:</b>	Assembly Bill 2859		
<b>AUTHOR:</b>	Assembly Member Low	<b>SPONSOR:</b>	
<b>VERSION:</b>	Amended in Senate 6/15/2016	<b>INTRODUCED:</b>	2/19/2016
<b>BILL STATUS:</b>	6/15/2016 Re-referred to Com. On APPR	<b>BILL LOCATION:</b>	Senate Appropriations
<b>SUBJECT:</b>	Professions and Vocations: Retired Category: Licenses	<b>RELATED BILLS:</b>	

**SUMMARY**

This bill would authorize any of the boards, bureaus, commissions, or programs within the Department of Consumer Affairs (DCA) to establish by regulations a system for a retired category of licensure for persons not actively engaged in the practice of their profession.

The retired licensee would not be able to engage in any activity for which a license is required unless the board by regulation specifies the criteria for a retired licensee to practice his or her profession or vocation.

This bill would also allow the holder of a retired license not to renew their license; and should a retired licensee want to restore his or her license to an active status then the holder of that license shall meet the specified requirements.

This bill would not apply to a board that has other statutory authority to establish a retired license.

**ANALYSIS**

This would authorize the Dental Board of California (Board) to create a retired license category which would allow a licensee to retire his/her license immediately in lieu of selecting the inactive status and electing to become delinquent in fees for five years in order for the license to be cancelled.

During the May 2016 Board meeting, concerns were raised regarding current use of the word "retired" and the proposed use of the word "retired." The Board directed staff to communicate with the author's office and as a result language was amended to excuse boards that have statutory authority to establish a retired license.

Should the Board proceed to establish a retired license category as specified by this proposed bill, the Board would need to promulgate regulations to differentiate between existing statutory provisions with that of the proposed bill in order to avoid confusion or misinterpretation between statutes; and to implement the proposed retired category.

## **REGISTERED SUPPORT/OPPOSITION (As of 06/07/2016)**

### **Support:**

California Board of Accountancy  
Contractors State License Board

### **Opposition:**

None on file.

## **BOARD POSITION**

The Board has not taken a position on the bill, but did direct staff to communicate with the author to raise concerns regarding the usage of the word “retired”. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Oppose
- Oppose unless Amended
- Neutral
- Watch
- No Action

Staff recommends taking a “Support” position on this bill as it would provide the Board the ability to establish a license status for those who no longer want to practice dentistry nor renew their license.

AMENDED IN SENATE JUNE 15, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 2859**

---

---

**Introduced by Assembly Member Low**

February 19, 2016

---

---

An act to add Section 463 to the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL’S DIGEST

AB 2859, as amended, Low. Professions and vocations: retired category: licenses.

Existing law provides for numerous boards, bureaus, commissions, or programs within the Department of Consumer Affairs that administer the licensing and regulation of various businesses and professions. Existing law authorizes any of the boards, bureaus, commissions, or programs within the department, except as specified, to establish by regulation a system for an inactive category of license for persons who are not actively engaged in the practice of their profession or vocation. Under existing law, the holder of an inactive license is prohibited from engaging in any activity for which a license is required. Existing law defines “board” for these purposes to include, unless expressly provided otherwise, a bureau, commission, committee, department, division, examining committee, program, and agency.

This bill would additionally authorize any of the ~~boards, bureaus, commissions, or programs~~ *boards* within the department to establish by regulation a system for a retired category of license for persons who are not actively engaged in the practice of their profession or ~~vocation, and vocation~~. *The bill would require that regulation to include specified provisions, including that a retired license be issued to a person with*

*either an active license or an inactive license that was not placed on inactive status for disciplinary reasons. The bill also would prohibit the holder of a retired license from engaging in any activity for which a license is required, unless regulation specifies the criteria for a retired licensee to practice his or her profession. The bill would authorize a board upon its own determination, and would require a board upon receipt of a complaint from any person, to investigate the actions of any licensee, including, among others, a person with a license that is retired or inactive. The bill would not apply to a board that has other statutory authority to establish a retired license.*

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 463 is added to the Business and
- 2 Professions Code, to read:
- 3 463. (a) Any of the ~~boards, bureaus, commissions, or programs~~
- 4 *boards* within the department may establish, by regulation, a
- 5 system for a retired category of licensure for persons who are not
- 6 actively engaged in the practice of their profession or vocation.
- 7 (b) The regulation shall contain the following:
- 8 (1) *A retired license shall be issued to a person with either an*
- 9 *active license or an inactive license that was not placed on inactive*
- 10 *status for disciplinary reasons.*
- 11 ~~(1)~~
- 12 (2) The holder of a retired license issued pursuant to this section
- 13 shall not engage in any activity for which a license is required,
- 14 unless the board, by regulation, specifies the criteria for a retired
- 15 licensee to practice his or her profession or vocation.
- 16 ~~(2)~~
- 17 (3) The holder of a retired license shall not be required to renew
- 18 that license.
- 19 ~~(3)~~
- 20 (4) In order for the holder of a retired license issued pursuant
- 21 to this section to restore his or her license to an active status, the
- 22 holder of that license shall meet all the following:
- 23 (A) Pay a fee established by statute or regulation.



1 (B) Certify, in a manner satisfactory to the board, that he or she  
2 has not committed an act or crime constituting grounds for denial  
3 of licensure.

4 (C) Comply with the fingerprint submission requirements  
5 established by regulation.

6 (D) If the board requires completion of continuing education  
7 for renewal of an active license, complete continuing education  
8 equivalent to that required for renewal of an active license, unless  
9 a different requirement is specified by the board.

10 (E) Complete any other requirements as specified by the board  
11 by regulation.

12 (c) A board may upon its own determination, and shall upon  
13 receipt of a complaint from any person, investigate the actions of  
14 any licensee, including a person with a license that either restricts  
15 or prohibits the practice of that person in his or her profession or  
16 vocation, including, but not limited to, a license that is retired,  
17 inactive, canceled, revoked, or suspended.

18 (d) *Subdivisions (a) and (b) shall not apply to a board that has*  
19 *other statutory authority to establish a retired license.*

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
AUGUST 2016 BOARD MEETING**

---

---

<b>BILL NUMBER:</b>	Senate Bill 482		
<b>AUTHOR:</b>	Senate Member Ricardo Lara	<b>SPONSOR:</b>	California Narcotic Officers' Association & Consumer Attorneys of California
<b>VERSION:</b>	Amended in Assembly 06/21/2016	<b>INTRODUCED:</b>	2/26/2015
<b>BILL STATUS:</b>	06/29 Set for Com. APPR hearing, but cancelled at request of author: to Suspend File	<b>BILL LOCATION:</b>	Assembly Appropriations
<b>SUBJECT:</b>	Controlled Substances: CURES Database	<b>RELATED BILLS:</b>	

**SUMMARY**

Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report specified information for each prescription of a Schedule II, Schedule III, or Schedule IV controlled substance to the department.

In amended form this bill would require prescribers of Schedule II or Schedule III controlled substances to consult with the CURES database before prescribing controlled substance to patient for the first time and once every four months thereafter if the substance remains part of the patient's treatment. Also, it prohibits the prescriber in prescribing additional Schedule II or Schedule III controlled substances to a patient who already has an existing prescription until there is a legitimate need for it. Additionally, the bill would provide that a prescriber is not in violation of the proposed requirements if at any time the CURES database is suspended or not accessible or there is some form of inability to access the CURES database in a timely manner due to an emergency, when the substance is prescribed to a patient receiving hospice care or when administered to the patient or other circumstances as specified.

**ANALYSIS**

In amended form, this bill would require the prescribing licensee to consult with the CURES database every four months instead of annually, if the patient is continuing to take the prescribed controlled substance. This would create a burden on the prescribing

licensee; however this does not affect the Dental Board of California (Board). The potential impact of this bill upon the Board is the minor cost of notifying its licensees of the requirement to check the CURES System which is minor and absorbable.

**REGISTERED SUPPORT/OPPOSITION (As of 6/14/2016)**

**Support:**

California Narcotic Officers' Association (co-sponsor)  
Consumer Attorneys of California (co-sponsor)  
California Chamber of Commerce  
California Teamsters Public Affairs Council  
Center for Public Interest Law  
Consumer Watchdog  
National Alliance on Mental Illness  
ShatterProof

**Opposition:**

California Medical Association

**BOARD POSITION**

The Board has not taken a position on the bill. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

Staff recommends taking a "WATCH" position on this bill.

AMENDED IN ASSEMBLY JUNE 21, 2016  
AMENDED IN ASSEMBLY JUNE 6, 2016  
AMENDED IN ASSEMBLY APRIL 7, 2016  
AMENDED IN SENATE APRIL 30, 2015  
AMENDED IN SENATE APRIL 16, 2015

**SENATE BILL**

**No. 482**

---

---

**Introduced by Senator Lara**

February 26, 2015

---

---

An act to amend Section 11165.1 of, and to add Section 11165.4 to, the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 482, as amended, Lara. Controlled substances: CURES database. Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report specified information for each prescription of a Schedule II, Schedule III, or Schedule IV controlled substance to the department.

This bill would require a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a controlled substance to consult the CURES database to review a patient's controlled substance history no earlier than 24 hours before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the

first time and at least ~~annually~~ *once every 4 months* thereafter if the substance remains part of the treatment of the patient. The bill would exempt a veterinarian from this requirement. The bill would also exempt a health care practitioner from this requirement under specified circumstances, including, among others, if prescribing, ordering, administering, furnishing, or dispensing a controlled substance to a patient receiving hospice care, to a patient admitted to a specified facility, or to a patient as part of a treatment for a surgical procedure in a specified facility if the quantity of the controlled substance does not exceed a nonrefillable 5-day supply of the controlled substance that is to be used in accordance with the directions for use. The bill would exempt a health care practitioner from this requirement if it is not reasonably possible for him or her to access the information in the CURES database in a timely manner, another health care practitioner or designee authorized to access the CURES database is not reasonably available, and the quantity of controlled substance prescribed, ordered, administered, furnished, or dispensed does not exceed a nonrefillable 5-day supply of the controlled substance that is to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

The bill would provide that a health care practitioner who knowingly fails to consult the CURES database is required to be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board. The bill would make the above-mentioned provisions operative 6 months after the Department of Justice certifies that the CURES database is ready for statewide use.

The bill would also exempt a health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, from civil or administrative liability arising from any false, incomplete, or inaccurate information submitted, to or reported by, the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 11165.1 of the Health and Safety Code
- 2 is amended to read:

1 11165.1. (a) (1) (A) (i) A health care practitioner authorized  
2 to prescribe, order, administer, furnish, or dispense Schedule II,  
3 Schedule III, or Schedule IV controlled substances pursuant to  
4 Section 11150 shall, before July 1, 2016, or upon receipt of a  
5 federal Drug Enforcement Administration (DEA) registration,  
6 whichever occurs later, submit an application developed by the  
7 Department of Justice to obtain approval to access information  
8 online regarding the controlled substance history of a patient that  
9 is stored on the Internet and maintained within the Department of  
10 Justice, and, upon approval, the department shall release to that  
11 practitioner the electronic history of controlled substances  
12 dispensed to an individual under his or her care based on data  
13 contained in the CURES Prescription Drug Monitoring Program  
14 (PDMP).

15 (ii) A pharmacist shall, before July 1, 2016, or upon licensure,  
16 whichever occurs later, submit an application developed by the  
17 Department of Justice to obtain approval to access information  
18 online regarding the controlled substance history of a patient that  
19 is stored on the Internet and maintained within the Department of  
20 Justice, and, upon approval, the department shall release to that  
21 pharmacist the electronic history of controlled substances dispensed  
22 to an individual under his or her care based on data contained in  
23 the CURES PDMP.

24 (B) An application may be denied, or a subscriber may be  
25 suspended, for reasons which include, but are not limited to, the  
26 following:

27 (i) Materially falsifying an application for a subscriber.

28 (ii) Failure to maintain effective controls for access to the patient  
29 activity report.

30 (iii) Suspended or revoked federal DEA registration.

31 (iv) Any subscriber who is arrested for a violation of law  
32 governing controlled substances or any other law for which the  
33 possession or use of a controlled substance is an element of the  
34 crime.

35 (v) Any subscriber accessing information for any other reason  
36 than caring for his or her patients.

37 (C) Any authorized subscriber shall notify the Department of  
38 Justice within 30 days of any changes to the subscriber account.

39 (2) A health care practitioner authorized to prescribe, order,  
40 administer, furnish, or dispense Schedule II, Schedule III, or

1 Schedule IV controlled substances pursuant to Section 11150 or  
2 a pharmacist shall be deemed to have complied with paragraph  
3 (1) if the licensed health care practitioner or pharmacist has been  
4 approved to access the CURES database through the process  
5 developed pursuant to subdivision (a) of Section 209 of the  
6 Business and Professions Code.

7 (b) Any request for, or release of, a controlled substance history  
8 pursuant to this section shall be made in accordance with guidelines  
9 developed by the Department of Justice.

10 (c) In order to prevent the inappropriate, improper, or illegal  
11 use of Schedule II, Schedule III, or Schedule IV controlled  
12 substances, the Department of Justice may initiate the referral of  
13 the history of controlled substances dispensed to an individual  
14 based on data contained in CURES to licensed health care  
15 practitioners, pharmacists, or both, providing care or services to  
16 the individual.

17 (d) The history of controlled substances dispensed to an  
18 individual based on data contained in CURES that is received by  
19 a practitioner or pharmacist from the Department of Justice  
20 pursuant to this section is medical information subject to the  
21 provisions of the Confidentiality of Medical Information Act  
22 contained in Part 2.6 (commencing with Section 56) of Division  
23 1 of the Civil Code.

24 (e) Information concerning a patient’s controlled substance  
25 history provided to a prescriber or pharmacist pursuant to this  
26 section shall include prescriptions for controlled substances listed  
27 in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code  
28 of Federal Regulations.

29 (f) A health care practitioner, pharmacist, and any person acting  
30 on behalf of a health care practitioner or pharmacist, when acting  
31 with reasonable care and in good faith, is not subject to civil or  
32 administrative liability arising from any false, incomplete, or  
33 inaccurate information submitted to, or reported by, the CURES  
34 database or for any resulting failure of the CURES database to  
35 accurately or timely report that information.

36 SEC. 2. Section 11165.4 is added to the Health and Safety  
37 Code, to read:

38 11165.4. (a) (1) (A) A health care practitioner authorized to  
39 prescribe, order, administer, furnish, or dispense a controlled  
40 substance shall consult the CURES database to review a patient’s

1 controlled substance history before prescribing a Schedule II,  
2 Schedule III, or Schedule IV controlled substance to the patient  
3 for the first time and at least ~~annually~~ *once every four months*  
4 thereafter if the substance remains part of the treatment of the  
5 patient.

6 (B) For purposes of this paragraph, “first time” means the initial  
7 occurrence in which a health care practitioner, in his or her role  
8 as a health care practitioner, intends to prescribe, order, administer,  
9 furnish, or dispense a Schedule II, Schedule III, or Schedule IV  
10 controlled substance to a patient and has not previously prescribed  
11 a controlled substance to the patient.

12 (2) A health care practitioner shall obtain a patient’s controlled  
13 substance history from the CURES database no earlier than 24  
14 hours before he or she prescribes, orders, administers, furnishes,  
15 or dispenses a Schedule II, Schedule III, or Schedule IV controlled  
16 substance to the patient.

17 (b) The duty to consult the CURES database, as described in  
18 subdivision (a), does not apply to veterinarians.

19 (c) The duty to consult the CURES database, as described in  
20 subdivision (a), does not apply to a health care practitioner in any  
21 of the following circumstances:

22 (1) If a health care practitioner prescribes, orders, or furnishes  
23 a controlled substance to be administered or dispensed to a patient  
24 while the patient is admitted to any of the following facilities or  
25 during an emergency transfer between any of the following  
26 facilities:

27 (A) A licensed clinic, as described in Chapter 1 (commencing  
28 with Section 1200) of Division 2.

29 (B) An outpatient setting, as described in Chapter 1.3  
30 (commencing with Section 1248) of Division 2.

31 (C) A health facility, as described in Chapter 2 (commencing  
32 with Section 1250) of Division 2.

33 (D) A county medical facility, as described in Chapter 2.5  
34 (commencing with Section 1440) of Division 2.

35 (2) When a health care practitioner prescribes, orders,  
36 administers, furnishes, or dispenses a controlled substance in the  
37 emergency department of a general acute care hospital if the  
38 quantity of the controlled substance does not exceed a ~~10-day~~  
39 *seven-day* supply of the controlled substance to be used in  
40 accordance with the directions for use.



- 1 (3) If a health care practitioner prescribes, orders, administers,  
2 furnishes, or dispenses a controlled substance to a patient as part  
3 of the patient’s treatment for a surgical procedure, if the quantity  
4 of the controlled substance does not exceed a nonrefillable five-day  
5 supply of the controlled substance to be used in accordance with  
6 the directions for use, in any of the following facilities:
- 7 (A) A licensed clinic, as described in Chapter 1 (commencing  
8 with Section 1200) of Division 2.
  - 9 (B) An outpatient setting, as described in Chapter 1.3  
10 (commencing with Section 1248) of Division 2.
  - 11 (C) A health facility, as described in Chapter 2 (commencing  
12 with Section 1250) of Division 2.
  - 13 (D) A county medical facility, as described in Chapter 2.5  
14 (commencing with Section 1440) of Division 2.
  - 15 (E) A place of practice, as defined in Section 1658 of the  
16 Business and Professions Code.
- 17 (4) If a health care practitioner prescribes, orders, administers,  
18 furnishes, or dispenses a controlled substance to a patient currently  
19 receiving hospice care, as defined in Section 1339.40.
- 20 (5) (A) If all of the following circumstances are satisfied:
- 21 (i) It is not reasonably possible for a health care practitioner to  
22 access the information in the CURES database in a timely manner.
  - 23 (ii) Another health care practitioner or designee authorized to  
24 access the CURES database is not reasonably available.
  - 25 (iii) The quantity of controlled substance prescribed, ordered,  
26 administered, furnished, or dispensed does not exceed a  
27 nonrefillable five-day supply of the controlled substance to be used  
28 in accordance with the directions for use and no refill of the  
29 controlled substance is allowed.
- 30 (B) A health care practitioner who does not consult the CURES  
31 database under subparagraph (A) shall document the reason he or  
32 she did not consult the database in the patient’s medical record.
- 33 (6) If the CURES database is not operational, as determined by  
34 the department, or when it cannot be accessed by a health care  
35 practitioner because of a temporary technological or electrical  
36 failure. A health care practitioner shall, without undue delay, seek  
37 to correct any cause of the temporary technological or electrical  
38 failure that is reasonably within his or her control.

1 (7) If the CURES database cannot be accessed because of  
2 technological limitations that are not reasonably within the control  
3 of a health care practitioner.

4 (8) If the CURES database cannot be accessed because of  
5 exceptional circumstances, as demonstrated by a health care  
6 practitioner.

7 (d) (1) A health care practitioner who knowingly fails to consult  
8 the CURES database, as described in subdivision (a), shall be  
9 referred to the appropriate state professional licensing board solely  
10 for administrative sanctions, as deemed appropriate by that board.

11 (2) This section does not create a private cause of action against  
12 a health care practitioner. This section does not limit a health care  
13 practitioner's liability for the negligent failure to diagnose or treat  
14 a patient.

15 (e) This section is not operative until six months after the  
16 Department of Justice certifies that the CURES database is ready  
17 for statewide use. The department shall notify the Secretary of  
18 State and the office of the Legislative Counsel of the date of that  
19 certification.

20 (f) All applicable state and federal privacy laws govern the  
21 duties required by this section.

22 (g) The provisions of this section are severable. If any provision  
23 of this section or its application is held invalid, that invalidity shall  
24 not affect other provisions or applications that can be given effect  
25 without the invalid provision or application.

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
AUGUST 2016 BOARD MEETING**

---

**BILL NUMBER:** Senate Bill 1155

**AUTHOR:** Senate Member Morrell

**SPONSOR:**

**VERSION:** Amended 06/23/2016

**INTRODUCED:** 02/18/2016

**BILL STATUS:** 6/29/2016 Do pass and re-  
refer to Com. On APPR

**BILL LOCATION:** Assembly  
Appropriations

**SUBJECT:** Professions and Vocations:  
Licenses: Military Service

**RELATED  
BILLS:**

**SUMMARY**

This bill proposes to require the Department of Consumer Affairs to establish and maintain a program that grants one fee waiver for the application and issuance of a license to an individual who is an honorably discharged veteran who contains satisfactory evidence of his/her "Certificate of Release or Discharge from Active Duty" (DD Form 214). This waiver is not applicable to the following:

- Renewal of a license
- Application for and issuance of an additional license, certificate, registration or permit associated with the initial license
- Application for an examination
- An application of or a license issued to a business or other entity.

**ANALYSIS**

At this time it is unknown how many honorably discharged veterans would be applying for licensure with the Dental Board of California (Board) to determine what the potential impact would be should this bill be enacted. It would be too premature to state that the impact of this bill would be negligible and absorbable.

**REGISTERED SUPPORT/OPPOSITION (As of 6/27/2016)**

Support:

American G.I. Forum of California  
AMVETS-Department of California  
California Association of County Veterans Service Officers  
California Dental Association  
Goodwill Southern California  
Military Officers Association of America, California Council of Chapters  
Veterans of Foreign Wars, California Department

Opposition:  
None on file.

**STAFF RECOMMENDATION**

The Board took a “WATCH” position on this bill during the May 2016 Board meeting. The Committee may consider recommending the Board to take one of the following actions regarding this bill:

- Support
- Oppose
- Oppose if Amended
- Watch
- Neutral
- No Action

Staff recommends the Board maintain its “WATCH” position on this bill.

AMENDED IN ASSEMBLY JUNE 23, 2016

AMENDED IN SENATE MAY 31, 2016

AMENDED IN SENATE MARCH 28, 2016

**SENATE BILL**

**No. 1155**

---

---

**Introduced by Senator Morrell**

February 18, 2016

---

---

An act to add Section 114.6 to the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

SB 1155, as amended, Morrell. Professions and vocations: licenses: military service.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes any licensee whose license expired while he or she was on active duty as a member of the California National Guard or the United States Armed Forces to reinstate his or her license without examination or penalty if certain requirements are met. Existing law also requires the boards to waive the renewal fees, continuing education requirements, and other renewal requirements, if applicable, of any licensee or registrant called to active duty as a member of the United States Armed Forces or the California National Guard, if certain requirements are met. Existing law requires each board to inquire in every application if the individual applying for licensure is serving in, or has previously served in, the military. Existing law, on and after July 1, 2016, requires a board within the Department of Consumer Affairs to expedite, and authorizes a board to assist, the initial licensure

process for an applicant who has served as an active duty member of the United States Armed Forces and was honorably discharged.

This bill, on and after January 1, 2018, would require every board within the Department of Consumer Affairs to grant a fee waiver for the application for and the issuance of an initial license to ~~an individual who is an honorably discharged veteran~~. *an applicant who supplies satisfactory evidence, as defined, to the board that the applicant has served as an active duty member of the California National Guard or the United States Armed Forces and was honorably discharged.* The bill would require that a veteran be granted only one fee waiver, except as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 114.6 is added to the Business and  
2 Professions Code, to read:

3 114.6. (a) (1) Notwithstanding any other provision of law,  
4 every board within the department shall grant a fee waiver for the  
5 application for and issuance of an initial license to ~~an individual~~  
6 ~~who is an honorably discharged veteran who served as an active~~  
7 ~~duty member of the California National Guard or the United States~~  
8 ~~Armed Forces. Under this program, all of the following apply:~~ *an*  
9 *applicant who supplies satisfactory evidence to the board that the*  
10 *applicant has served as an active duty member of the California*  
11 *National Guard or the United States Armed Forces and was*  
12 *honorably discharged.*

13 (2) *For purposes of this section, “satisfactory evidence” means*  
14 *a completed “Certificate of Release or Discharge from Active*  
15 *Duty” (DD Form 214).*

16 (b) *Under this program, all of the following apply:*

17 (a)

18 (1) A veteran shall be granted only one fee waiver, except as  
19 specified in ~~subdivision (b)~~. *paragraph (2).* After a fee waiver has  
20 been issued by any board within the department pursuant to this  
21 section, the veteran is no longer eligible for a waiver.

22 (b)

- 1 (2) If a board charges a fee for the application for a license and  
2 another fee for the issuance of a license, the veteran shall be granted  
3 fee waivers for both the application for and issuance of a license.  
4 ~~(e)~~
- 5 (3) The fee waiver shall apply only to an application of and a  
6 license issued to an individual veteran and not to an application  
7 of or a license issued to an individual veteran on behalf of a  
8 business or other entity.  
9 ~~(d)~~
- 10 (4) A waiver shall not be issued for any of the following:  
11 ~~(1)~~
- 12 (A) Renewal of a license.  
13 ~~(2)~~
- 14 (B) The application for and issuance of an additional license, a  
15 certificate, a registration, or a permit associated with the initial  
16 license.  
17 ~~(3)~~
- 18 (C) The application for an examination.  
19 ~~(e)~~
- 20 (c) This section shall become operative on January 1, 2018.

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
AUGUST 2016 BOARD MEETING**

---

---

<b>BILL NUMBER:</b>	Senate Bill 1348		
<b>AUTHOR:</b>	Senate Member Anthony Cannella	<b>SPONSOR:</b>	
<b>VERSION:</b>	Amended in Senate 05/31/2016	<b>INTRODUCED:</b>	2/19/2016
<b>BILL STATUS:</b>	6/30/2016 Read second time. Ordered to consent	<b>BILL LOCATION:</b>	Assembly
<b>SUBJECT:</b>	Licensure Applications: Military Experience	<b>RELATED BILLS:</b>	

**SUMMARY**

In amended form, this proposed bill would amend Business and Professions Code (Code) Section 114.5 by requiring, if the governing board authorizes veterans to apply military experience and training towards licensure requirements, to post information on its Internet Website advising veteran applicants about their ability to apply military experience and training towards licensure requirements.

**ANALYSIS**

This bill would not fiscally impact the Dental Board of California (Board), because the proposed bill would require the Dental Board to post on its Internet Website a statement advising veteran applicants of their ability to apply their military experience and training towards the licensure requirements.

In 2013, the legislature passed and the Governor signed AB 1057 (Medina) requiring licensing boards to ask on every application for licensure if the applicant is serving in or has previously served in the military.

Additionally, current law contains a provision where experience, knowledge, and skills obtained within the armed services should be permitted, if applicable, to apply to the requirements of the regulated profession. Current law requires boards to specify the method of implementation to meet the licensure requirements for the particular business, occupation, or profession regulated and requires boards to consult with the Department of Veteran Affairs and the Military Department before adopting the applicable rules and regulations as required by current law.

This bill intends to close the technical gap in the Code by ensuring veterans receive notification in writing when applying for licensure with boards that accept military experience and training towards their licensure requirements.

**REGISTERED SUPPORT/OPPOSITION (As of 6/20/2016)**



Support:

California Board of Accountancy

Opposition:

None on file.

**BOARD POSITION**

The Board took a “WATCH” position on this bill during the May 2016 Board meeting. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

Staff recommends taking a “SUPPORT” position on this bill, because it would ensure veterans receive notification that they are apply to apply their military experience and training towards their licensure requirements; and there would be no fiscal impact as a result of implementing the proposed language of the bill.

**Introduced by Senator Cannella**

February 19, 2016

---

---

An act to amend Section 114.5 of the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

SB 1348, as amended, Cannella. Licensure applications: military experience.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law requires each board to inquire in every application for licensure if the individual applying for licensure is serving in, or has previously served in, the military.

This bill would require each board, with a governing law authorizing veterans to apply military experience and training towards licensure requirements, to ~~modify their application for licensure to advise veteran applicants~~ *post information on the board's Internet Web site about their the ability of veteran applicants to apply that their military* experience and training towards licensure requirements.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 114.5 of the Business and Professions
- 2 Code is amended to read:

1 114.5. (a) Each board shall inquire in every application for  
2 licensure if the individual applying for licensure is serving in, or  
3 has previously served in, the military.

4 (b) If a board's governing law authorizes veterans to apply  
5 military experience and training towards licensure requirements,  
6 that board shall ~~modify their application for licensure to advise~~  
7 ~~veteran applicants~~ *post information on the board's Internet Web*  
8 *site about their the ability of veteran applicants to apply military*  
9 *experience and training towards licensure requirements.*

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
AUGUST 2016 BOARD MEETING**

---

<b>BILL NUMBER:</b>	Senate Bill 1444	<b>SPONSOR:</b>	
<b>AUTHOR:</b>	Senator Hertzberg	<b>INTRODUCED:</b>	3/19/2016
<b>VERSION:</b>	Amended in Senate 4/19/2016	<b>BILL LOCATION:</b>	Assembly Appropriation
<b>BILL STATUS:</b>	6/28/2016 Do pass and re- refer to Com on APPR	<b>RELATED BILLS:</b>	
<b>SUBJECT:</b>	State Government: Computerized Personal Information Security Plans		

**SUMMARY**

The Legislature through this bill finds and declares that in the last four years malware and hacking attacks have risen dramatically and account for a vast majority of the records that have been breached and have resulted in the greatest risk for massive disclosure of sensitive personal information.

This bill proposes to require state agencies that own or license computerized data that includes personal information to prepare a computerized personal information security plan that details the agency's strategy to respond to a security breach of a computerized personal information and associated consequences caused by the such a disclosure.

The bill would require the computerized personal information security plan to include the following:

- A statement of purposes and objectives for the plan
- An inventory of the computerized personal information stored or transmitted by the agency
- Identification of resources necessary to implement the plan
- Identification of an incident response team tasked with mitigating and responding to a breach or an imminent threat of a breach
- Communication procedures with the incident response team, the agency and those outside of the agency in the event of a breach
- Policies for training the incident response team and the agency on implementation of this proposal
- Process to review and improve the plan

The amended bill would define "personal information" as consistent with Civil Code Sections 1798.3(a) and 1798.29(g).

**ANALYSIS**

This would require the Department of Consumer Affairs (DCA) to create an incident response team and implement a strategy to respond to a security breach. Under existing law, state agencies have a duty to protect personal information entrusted to their care from a data breach and this bill would require state agencies like DCA to develop a response team and a strategy in addressing such breaches should they occur. Since, the Dental Board and its licensees utilize BreEZe for day to day functions and processing of licensure and permitting applications, personal information is constantly utilized and inputted.

Though the bill does not require the Dental Board to create and implement a team and strategy, the actions to be taken by DCA as a result of this bill would impact the Dental Board.

### **REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

### **BOARD POSITION**

The Board took a "WATCH" position on this bill during the May 2016 Board meeting. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

Staff recommends continuing to maintain the "WATCH" position on this bill, because it is still undetermined how it would affect the Board.

AMENDED IN SENATE APRIL 19, 2016  
AMENDED IN SENATE MARCH 31, 2016

**SENATE BILL**

**No. 1444**

---

---

**Introduced by Senator Hertzberg**

February 19, 2016

---

---

An act to add Section 1798.21.5 to the Civil Code, relating to personal information.

LEGISLATIVE COUNSEL'S DIGEST

SB 1444, as amended, Hertzberg. State government: computerized personal information security plans.

The Information Practices Act of 1977 requires an agency, as defined, to maintain in its records only that personal information, as defined, that is relevant and necessary to accomplish a purpose of the agency required or authorized by the California Constitution or statute or mandated by the federal government. That law requires each agency to establish appropriate and reasonable administrative, technical, and physical safeguards to ensure compliance with this law, to ensure the security and confidentiality of records, and to protect against anticipated threats or hazards to the security or integrity of the records that could result in any injury. Existing law requires an agency that owns or licenses computerized data that includes personal information to disclose a breach of the security of the system in the most expedient time possible and without unreasonable delay, as specified.

This bill would require an agency that owns or licenses computerized data that includes personal information to prepare a computerized personal information security plan that details the agency's strategy to respond to a security breach of computerized personal information and

associated consequences caused by the disclosed personal information. The bill would make legislative findings and declarations in this regard.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. The Legislature finds and declares all of the  
2 following:

3 (a) The Attorney General reported that since 2012, 657 data  
4 breaches of the kind affecting more than 500 Californians have  
5 exposed over 49 million records to fraudulent use.

6 (b) Malware and hacking attacks have risen dramatically in the  
7 past four years and account for a vast majority of the records that  
8 have been breached. These types of attacks present the greatest  
9 risk for massive disclosure of sensitive personal information,  
10 including, among others, social security numbers, driver’s licenses,  
11 and dates of birth.

12 (c) Numerous state agencies hold records of millions of  
13 Californians and present the potential for large breaches of personal  
14 information in the future.

15 (d) Information technology professionals consider data breaches  
16 to be inevitable for organizations of all sizes and recommend the  
17 development and regular updating of plans and procedures designed  
18 to detect and halt breaches, notify affected Californians, and  
19 mitigate the damage caused by the data breaches.

20 SEC. 2. Section 1798.21.5 is added to the Civil Code, to read:

21 1798.21.5. (a) An agency that owns or licenses computerized  
22 data that includes personal information shall prepare a  
23 computerized personal information security plan that details the  
24 agency’s strategy to respond to a security breach of computerized  
25 personal information and associated consequences caused by the  
26 disclosed personal information. A computerized personal  
27 information security plan shall include, but is not limited to, all of  
28 the following:

29 ~~(a)~~

30 (1) A statement of the purpose and objectives for the plan.

31 ~~(b)~~

32 (2) An inventory of the computerized personal information  
33 stored or transmitted by the agency.

1     ~~(e)~~

2     (3) Identification of resources necessary to implement the plan.

3     ~~(d)~~

4     (4) Identification of an incident response team tasked with  
5 mitigating and responding to a breach, or an imminent threat of a  
6 breach, to the security of computerized personal information.

7     ~~(e)~~

8     (5) Procedures for communications within the incident response  
9 team and between the incident response team, other individuals  
10 within the agency, and individuals outside the agency that need to  
11 be notified in the event of a breach of the security of computerized  
12 personal information.

13     ~~(f)~~

14     (6) Policies for training the incident response team and the  
15 agency on the implementation of the computerized personal  
16 information security plan, including, but not limited to, the use of  
17 practice drills.

18     ~~(g)~~

19     (7) A process to review and improve the computerized personal  
20 information security plan.

21     ***(b) For purposes of this section, “personal information”***  
22 ***includes information described in subdivision (a) of Section 1798.3***  
23 ***and subdivision (g) of Section 1798.29.***



**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
AUGUST 2016 BOARD MEETING**

---

<b>BILL NUMBER:</b>	Senate Bill 1478		
<b>AUTHOR:</b>	Senate Committee of Business, Professions, and Economic Development	<b>SPONSOR:</b>	
<b>VERSION:</b>	Introduced 3/10/2016	<b>INTRODUCED:</b>	3/10/2016
<b>BILL STATUS:</b>	6/30 Ordered to third reading	<b>BILL LOCATION:</b>	Assembly
<b>SUBJECT:</b>	Healing Arts	<b>RELATED BILLS:</b>	

**SUMMARY**

This bill would delete the provision relating to the establishment of the Task Force on Culturally and Linguistically Competent Physicians and Dentists and its corresponding tasks.

Additionally, this bill amends Business and Professions Code (Code) Sections 1632(a) and 1634.1(d) to make a technical update to the name of a Board required national examination for licensure due to the integration of the two parts of the National Board Dental Examination that is due to become effective in 2017.

**ANALYSIS**

The proposal to delete the provision relating to the Task Force on Culturally and Linguistically Competent Physicians and Dentists is a technical non-substantive change that would not impact the Dental Board, as this Task Force has not been active for some time.

Additionally, the amendment relating to the integration of the two parts of the National Board Dental Examination would be a technical non-substantive change in order to address the change that will take place in 2017 and as a result, it would not impact the Board.

**REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

**BOARD POSITION**

The Board took a "SUPPORT" position on the bill during the May 2016 Board meeting.

**Introduced by Committee on Business, Professions and Economic Development (Senators Hill (Chair), Bates, Berryhill, Block, Galgiani, Hernandez, Jackson, Mendoza, and Wieckowski)**

March 10, 2016

---

---

An act to amend Sections 1632, 1634.1, 2467, 4980.36, 4980.37, 4980.43, 4980.78, 4980.79, 4992.05, 4996.18, 4996.23, 4999.12, 4999.40, 4999.47, 4999.52, 4999.60, 4999.61, and 4999.120 of, to add Sections 4980.09 and 4999.12.5 to, to repeal Sections 852, 2029, 4980.40.5, and 4999.54 of, and to repeal Article 16 (commencing with Section 2380) of Chapter 5 of Division 2 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1478, as introduced, Committee on Business, Professions and Economic Development. Healing arts.

Existing law provides for the licensure and regulation of healing arts professions and vocations by boards within the Department of Consumer Affairs.

(1) Existing law establishes the Task Force on Culturally and Linguistically Competent Physicians and Dentists. Existing law requires the task force to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency, identify the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices and assess the need for voluntary certification standards and examinations for cultural and linguistic competency.

This bill would delete those provisions.

(2) The Dental Practice Act provides for the licensure and regulation of dentists by the Dental Board of California. Existing law requires

each applicant to, among other things, successfully complete the Part I and Part II written examinations of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

This bill would instead require the applicant to successfully complete the written examination of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(3) The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California.

Existing law requires the board to keep a copy of a complaint it receives regarding the poor quality of care rendered by a licensee for 10 years from the date the board receives the complaint, as provided.

This bill would delete that requirement.

Existing law creates the Bureau of Medical Statistics within the board. Under existing law, the purpose of the bureau is to provide the board with statistical information necessary to carry out their functions of licensing, medical education, medical quality, and enforcement.

This bill would abolish that bureau.

(4) Under existing law, the California Board of Podiatric Medicine is responsible for the certification and regulation of the practice of podiatric medicine. Existing law requires the board to annually elect one of its members to act as president and vice president.

This bill would instead require the board to elect from its members a president, a vice president, and a secretary.

(5) The Board of Behavioral Sciences is responsible for administering, among others, the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act.

(A) Existing law, the Licensed Marriage and Family Therapist Act, provides for the regulation of the practice of marriage and family therapy by the Board of Behavioral Sciences. A violation of the act is a crime. Existing law requires the licensure of marriage and family therapists and the registration of marriage and family therapist interns. Under existing law, an “intern” is defined as an unlicensed person who has earned his or her master’s or doctoral degree qualifying him or her for licensure and is registered with the board. Existing law prohibits the abbreviation “MFTI” from being used in an advertisement unless the title “marriage and family therapist registered intern” appears in the advertisement.

Existing law, the Licensed Professional Clinical Counselor Act, provides for the regulation of the practice of professional clinical

counseling by the Board of Behavioral Sciences. Existing law requires the licensure of professional clinical counselors and the registration of professional clinical counselor interns. Under existing law, an “intern” is defined as an unlicensed person who meets specified requirements for registration and is registered with the board.

This bill, commencing January 1, 2018, would provide that certain specified titles using the term “intern” or any reference to the term “intern” in those acts shall be deemed to be a reference to an “associate,” as specified. Because this bill would change the definition of a crime, it would impose a state-mandated local program.

(B) The Licensed Marriage and Family Therapist Act generally requires specified applicants for licensure and registration to meet certain educational degree requirements, including having obtained that degree from a school, college, or university that, among other things, is accredited by a regional accrediting agency recognized by the United States Department of Education.

This bill would authorize that accreditation to be by a regional or national institutional accrediting agency recognized by the United States Department of Education.

Under the Licensed Marriage and Family Therapist Act, a specified doctoral or master’s degree approved by the Bureau for Private Postsecondary and Vocational Education as of June 30, 2007, is considered by the Board of Behavioral Sciences to meet the specified licensure and registration requirements if the degree is conferred on or before July 1, 2010. As an alternative, existing law requires the Board of Behavioral Sciences to accept those doctoral or master's degrees as equivalent degrees if those degrees are conferred by educational institutions accredited by specified associations.

This bill would delete those provisions.

(C) Under the Licensed Marriage and Family Therapist Act, an applicant for licensure is required to complete experience related to the practice of marriage and family therapy under the supervision of a supervisor. Existing law requires applicants, trainees who are unlicensed persons enrolled in an educational program to qualify for licensure, and interns who are unlicensed persons who have completed an educational program and is registered with the board to be at all times under the supervision of a supervisor. Existing law requires interns and trainees to only gain supervised experience as an employee or volunteer and prohibits experience from being gained as an independent contractor. Similarly, the Licensed Professional Clinical Counselor Act requires

clinical counselor trainees, interns, and applicants to perform services only as an employee or as a volunteer. The Licensed Professional Clinical Counselor Act prohibits gaining mental health experience by interns or trainees as an independent contractor.

The Clinical Social Worker Practice Act requires applicants to complete supervised experience related to the practice of clinical social work.

This bill would prohibit these persons from being employed as independent contractors and from gaining experience for work performed as an independent contractor reported on a specified tax form.

(D) The Licensed Professional Clinical Counselor Act defines the term “accredited” for the purposes of the act to mean a school, college, or university accredited by the Western Association of Schools and Colleges, or its equivalent regional accrediting association. The act requires each educational institution preparing applicants to qualify for licensure to notify each of its students in writing that its degree program is designed to meet specified examination eligibility or registration requirements and to certify to the Board of Behavioral Sciences that it has provided that notice.

This bill would re-define “accredited” to mean a school, college, or university accredited by a regional or national institutional accrediting agency that is recognized by the United States Department of Education. The bill would additionally require an applicant for registration or licensure to submit to the Board of Behavioral Sciences a certification from the applicant’s educational institution specifying that the curriculum and coursework complies with those examination eligibility or registration requirements.

(6) This bill would additionally delete various obsolete provisions, make conforming changes, and make other nonsubstantive changes.

(7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 852 of the Business and Professions Code  
2 is repealed.

3 ~~852. (a) The Task Force on Culturally and Linguistically~~  
4 ~~Competent Physicians and Dentists is hereby created and shall~~  
5 ~~consist of the following members:~~

6 ~~(1) The State Director of Health Services and the Director of~~  
7 ~~Consumer Affairs, who shall serve as cochairs of the task force.~~

8 ~~(2) The Executive Director of the Medical Board of California.~~

9 ~~(3) The Executive Director of the Dental Board of California.~~

10 ~~(4) One member appointed by the Senate Committee on Rules.~~

11 ~~(5) One member appointed by the Speaker of the Assembly.~~

12 ~~(b) Additional task force members shall be appointed by the~~  
13 ~~Director of Consumer Affairs, in consultation with the State~~  
14 ~~Director of Health Services, as follows:~~

15 ~~(1) Representatives of organizations that advocate on behalf of~~  
16 ~~California licensed physicians and dentists.~~

17 ~~(2) California licensed physicians and dentists that provide~~  
18 ~~health services to members of language and ethnic minority groups.~~

19 ~~(3) Representatives of organizations that advocate on behalf of,~~  
20 ~~or provide health services to, members of language and ethnic~~  
21 ~~minority groups.~~

22 ~~(4) Representatives of entities that offer continuing education~~  
23 ~~for physicians and dentists.~~

24 ~~(5) Representatives of California's medical and dental schools.~~

25 ~~(6) Individuals with experience in developing, implementing,~~  
26 ~~monitoring, and evaluating cultural and linguistic programs.~~

27 ~~(e) The duties of the task force shall include the following:~~

28 ~~(1) Developing recommendations for a continuing education~~  
29 ~~program that includes language proficiency standards of foreign~~  
30 ~~language to be acquired to meet linguistic competency.~~

31 ~~(2) Identifying the key cultural elements necessary to meet~~  
32 ~~cultural competency by physicians, dentists, and their offices.~~

33 ~~(3) Assessing the need for voluntary certification standards and~~  
34 ~~examinations for cultural and linguistic competency.~~

35 ~~(d) The task force shall hold hearings and convene meetings to~~  
36 ~~obtain input from persons belonging to language and ethnic~~  
37 ~~minority groups to determine their needs and preferences for having~~  
38 ~~culturally competent medical providers. These hearings and~~

1 meetings shall be convened in communities that have large  
2 populations of language and ethnic minority groups.

3 (e) ~~The task force shall report its findings to the Legislature and~~  
4 ~~appropriate licensing boards within two years after creation of the~~  
5 ~~task force.~~

6 (f) ~~The Medical Board of California and the Dental Board of~~  
7 ~~California shall pay the state administrative costs of implementing~~  
8 ~~this section.~~

9 (g) ~~Nothing in this section shall be construed to require~~  
10 ~~mandatory continuing education of physicians and dentists.~~

11 SEC. 2. Section 1632 of the Business and Professions Code is  
12 amended to read:

13 1632. (a) The board shall require each applicant to successfully  
14 complete the ~~Part I and Part II written examinations~~ *written*  
15 *examination* of the National Board Dental Examination of the Joint  
16 Commission on National Dental Examinations.

17 (b) The board shall require each applicant to successfully  
18 complete an examination in California law and ethics developed  
19 and administered by the board. The board shall provide a separate  
20 application for this examination. The board shall ensure that the  
21 law and ethics examination reflects current law and regulations,  
22 and ensure that the examinations are randomized. Applicants shall  
23 submit this application and required fee to the board in order to  
24 take this examination. In addition to the aforementioned  
25 application, the only other requirement for taking this examination  
26 shall be certification from the dean of the qualifying dental school  
27 attended by the applicant that the applicant has graduated, or will  
28 graduate, or is expected to graduate. Applicants who submit  
29 completed applications and certification from the dean at least 15  
30 days prior to a scheduled examination shall be scheduled to take  
31 the examination. Successful results of the examination shall, as  
32 established by board regulation, remain valid for two years from  
33 the date that the applicant is notified of having passed the  
34 examination.

35 (c) Except as otherwise provided in Section 1632.5, the board  
36 shall require each applicant to have taken and received a passing  
37 score on one of the following:

38 (1) A portfolio examination of the applicant's competence to  
39 enter the practice of dentistry. This examination shall be conducted  
40 while the applicant is enrolled in a dental school program at a

1 board-approved school located in California. This examination  
2 shall utilize uniform standards of clinical experiences and  
3 competencies, as approved by the board pursuant to Section 1632.1.  
4 The applicant shall pass a final assessment of the submitted  
5 portfolio at the end of his or her dental school program. Before  
6 any portfolio assessment may be submitted to the board, the  
7 applicant shall remit the required fee to the board to be deposited  
8 into the State Dentistry Fund, and a letter of good standing signed  
9 by the dean of his or her dental school or his or her delegate stating  
10 that the applicant has graduated or will graduate with no pending  
11 ethical issues.

12 (A) The portfolio examination shall not be conducted until the  
13 board adopts regulations to carry out this paragraph. The board  
14 shall post notice on its Internet Web site when these regulations  
15 have been adopted.

16 (B) The board shall also provide written notice to the Legislature  
17 and the Legislative Counsel when these regulations have been  
18 adopted.

19 (2) A clinical and written examination administered by the  
20 Western Regional Examining Board, which board shall determine  
21 the passing score for that examination.

22 (d) Notwithstanding subdivision (b) of Section 1628, the board  
23 is authorized to do either of the following:

24 (1) Approve an application for examination from, and to  
25 examine an applicant who is enrolled in, but has not yet graduated  
26 from, a reputable dental school approved by the board.

27 (2) Accept the results of an examination described in paragraph  
28 (2) of subdivision (c) submitted by an applicant who was enrolled  
29 in, but had not graduated from, a reputable dental school approved  
30 by the board at the time the examination was administered.

31 In either case, the board shall require the dean of that school or  
32 his or her delegate to furnish satisfactory proof that the applicant  
33 will graduate within one year of the date the examination was  
34 administered or as provided in paragraph (1) of subdivision (c).

35 SEC. 3. Section 1634.1 of the Business and Professions Code  
36 is amended to read:

37 1634.1. Notwithstanding Section 1634, the board may grant a  
38 license to practice dentistry to an applicant who submits all of the  
39 following to the board:



1 (a) A completed application form and all fees required by the  
2 board.

3 (b) Satisfactory evidence of having graduated from a dental  
4 school approved by the board or by the Commission on Dental  
5 Accreditation of the American Dental Association.

6 (c) Satisfactory evidence of having completed a clinically based  
7 advanced education program in general dentistry or an advanced  
8 education program in general practice residency that is, at  
9 minimum, one year in duration and is accredited by either the  
10 Commission on Dental Accreditation of the American Dental  
11 Association or a national accrediting body approved by the board.  
12 The advanced education program shall include a certification of  
13 clinical residency program completion approved by the board, to  
14 be completed upon the resident’s successful completion of the  
15 program in order to evaluate his or her competence to practice  
16 dentistry in the state.

17 (d) Satisfactory evidence of having successfully completed the  
18 written ~~examinations~~ *examination* of the National Board Dental  
19 Examination of the Joint Commission on National Dental  
20 Examinations.

21 (e) Satisfactory evidence of having successfully completed an  
22 examination in California law and ethics.

23 (f) Proof that the applicant has not failed the examination for  
24 licensure to practice dentistry under this chapter within five years  
25 prior to the date of his or her application for a license under this  
26 chapter.

27 SEC. 4. Section 2029 of the Business and Professions Code is  
28 repealed.

29 ~~2029. The board shall keep a copy of a complaint it receives  
30 regarding the poor quality of care rendered by a licensee for 10  
31 years from the date the board receives the complaint. For retrieval  
32 purposes, these complaints shall be filed by the licensee’s name  
33 and license number.~~

34 SEC. 5. Article 16 (commencing with Section 2380) of Chapter  
35 5 of Division 2 of the Business and Professions Code is repealed.

36 SEC. 6. Section 2467 of the Business and Professions Code is  
37 amended to read:

38 2467. (a) The board may convene from time to time as it deems  
39 necessary.

1 (b) Four members of the board constitute a quorum for the  
2 transaction of business at any meeting.

3 (c) It shall require the affirmative vote of a majority of those  
4 members present at a meeting, those members constituting at least  
5 a quorum, to pass any motion, resolution, or measure.

6 (d) The board shall ~~annually elect one of~~ *from* its members ~~to~~  
7 ~~act as president and a member to act as a president, a vice-president~~  
8 *president, and a secretary* who shall hold their respective positions  
9 at the pleasure of the board. The president may call meetings of  
10 the board and any duly appointed committee at a specified time  
11 and place.

12 SEC. 7. Section 4980.09 is added to the Business and  
13 Professions Code, to read:

14 4980.09. (a) The title “marriage and family therapist intern”  
15 or “marriage and family therapist registered intern” is hereby  
16 renamed “associate marriage and family therapist” or “registered  
17 associate marriage and family therapist,” respectively. Any  
18 reference in statute or regulation to a “marriage and family therapist  
19 intern” or “marriage and family therapist registered intern” shall  
20 be deemed a reference to an “associate marriage and family  
21 therapist” or “registered associate marriage and family therapist.”

22 (b) Nothing in this section shall be construed to expand or  
23 constrict the scope of practice of a person licensed or registered  
24 pursuant to this chapter.

25 (c) This section shall become operative January 1, 2018.

26 SEC. 8. Section 4980.36 of the Business and Professions Code  
27 is amended to read:

28 4980.36. (a) This section shall apply to the following:

29 (1) Applicants for licensure or registration who begin graduate  
30 study before August 1, 2012, and do not complete that study on  
31 or before December 31, 2018.

32 (2) Applicants for licensure or registration who begin graduate  
33 study before August 1, 2012, and who graduate from a degree  
34 program that meets the requirements of this section.

35 (3) Applicants for licensure or registration who begin graduate  
36 study on or after August 1, 2012.

37 (b) To qualify for a license or registration, applicants shall  
38 possess a doctoral or master’s degree meeting the requirements of  
39 this section in marriage, family, and child counseling, marriage  
40 and family therapy, couple and family therapy, psychology, clinical

1 psychology, counseling psychology, or counseling with an  
2 emphasis in either marriage, family, and child counseling or  
3 marriage and family therapy, obtained from a school, college, or  
4 university approved by the Bureau for Private Postsecondary  
5 Education, or accredited by either the Commission on Accreditation  
6 for Marriage and Family Therapy Education, or a regional *or*  
7 *national institutional* accrediting agency that is recognized by the  
8 United States Department of Education. The board has the authority  
9 to make the final determination as to whether a degree meets all  
10 requirements, including, but not limited to, course requirements,  
11 regardless of accreditation or approval.

12 (c) A doctoral or master's degree program that qualifies for  
13 licensure or registration shall do the following:

14 (1) Integrate all of the following throughout its curriculum:

15 (A) Marriage and family therapy principles.

16 (B) The principles of mental health recovery-oriented care and  
17 methods of service delivery in recovery-oriented practice  
18 environments, among others.

19 (C) An understanding of various cultures and the social and  
20 psychological implications of socioeconomic position, and an  
21 understanding of how poverty and social stress impact an  
22 individual's mental health and recovery.

23 (2) Allow for innovation and individuality in the education of  
24 marriage and family therapists.

25 (3) Encourage students to develop the personal qualities that  
26 are intimately related to effective practice, including, but not  
27 limited to, integrity, sensitivity, flexibility, insight, compassion,  
28 and personal presence.

29 (4) Permit an emphasis or specialization that may address any  
30 one or more of the unique and complex array of human problems,  
31 symptoms, and needs of Californians served by marriage and  
32 family therapists.

33 (5) Provide students with the opportunity to meet with various  
34 consumers and family members of consumers of mental health  
35 services to enhance understanding of their experience of mental  
36 illness, treatment, and recovery.

37 (d) The degree described in subdivision (b) shall contain no less  
38 than 60 semester or 90 quarter units of instruction that includes,  
39 but is not limited to, the following requirements:

40 (1) Both of the following:

- 1 (A) No less than 12 semester or 18 quarter units of coursework  
2 in theories, principles, and methods of a variety of  
3 psychotherapeutic orientations directly related to marriage and  
4 family therapy and marital and family systems approaches to  
5 treatment and how these theories can be applied therapeutically  
6 with individuals, couples, families, adults, including elder adults,  
7 children, adolescents, and groups to improve, restore, or maintain  
8 healthy relationships.
- 9 (B) Practicum that involves direct client contact, as follows:
- 10 (i) A minimum of six semester or nine quarter units of practicum  
11 in a supervised clinical placement that provides supervised  
12 fieldwork experience.
- 13 (ii) A minimum of 150 hours of face-to-face experience  
14 counseling individuals, couples, families, or groups.
- 15 (iii) A student must be enrolled in a practicum course while  
16 counseling clients, except as specified in subdivision (c) of Section  
17 4980.42.
- 18 (iv) The practicum shall provide training in all of the following  
19 areas:
- 20 (I) Applied use of theory and psychotherapeutic techniques.  
21 (II) Assessment, diagnosis, and prognosis.  
22 (III) Treatment of individuals and premarital, couple, family,  
23 and child relationships, including trauma and abuse, dysfunctions,  
24 healthy functioning, health promotion, illness prevention, and  
25 working with families.
- 26 (IV) Professional writing, including documentation of services,  
27 treatment plans, and progress notes.
- 28 (V) How to connect people with resources that deliver the  
29 quality of services and support needed in the community.
- 30 (v) Educational institutions are encouraged to design the  
31 practicum required by this subparagraph to include marriage and  
32 family therapy experience in low income and multicultural mental  
33 health settings.
- 34 (vi) In addition to the 150 hours required in clause (ii), 75 hours  
35 of either of the following, or a combination thereof:
- 36 (I) Client centered advocacy, as defined in Section 4980.03.  
37 (II) Face-to-face experience counseling individuals, couples,  
38 families, or groups.
- 39 (2) Instruction in all of the following:

- 1 (A) Diagnosis, assessment, prognosis, and treatment of mental  
2 disorders, including severe mental disorders, evidence-based  
3 practices, psychological testing, psychopharmacology, and  
4 promising mental health practices that are evaluated in peer  
5 reviewed literature.
- 6 (B) Developmental issues from infancy to old age, including  
7 instruction in all of the following areas:
- 8 (i) The effects of developmental issues on individuals, couples,  
9 and family relationships.
- 10 (ii) The psychological, psychotherapeutic, and health  
11 implications of developmental issues and their effects.
- 12 (iii) Aging and its biological, social, cognitive, and  
13 psychological aspects. This coursework shall include instruction  
14 on the assessment and reporting of, as well as treatment related  
15 to, elder and dependent adult abuse and neglect.
- 16 (iv) A variety of cultural understandings of human development.
- 17 (v) The understanding of human behavior within the social  
18 context of socioeconomic status and other contextual issues  
19 affecting social position.
- 20 (vi) The understanding of human behavior within the social  
21 context of a representative variety of the cultures found within  
22 California.
- 23 (vii) The understanding of the impact that personal and social  
24 insecurity, social stress, low educational levels, inadequate housing,  
25 and malnutrition have on human development.
- 26 (C) The broad range of matters and life events that may arise  
27 within marriage and family relationships and within a variety of  
28 California cultures, including instruction in all of the following:
- 29 (i) A minimum of seven contact hours of training or coursework  
30 in child abuse assessment and reporting as specified in Section 28,  
31 and any regulations promulgated thereunder.
- 32 (ii) Spousal or partner abuse assessment, detection, intervention  
33 strategies, and same gender abuse dynamics.
- 34 (iii) Cultural factors relevant to abuse of partners and family  
35 members.
- 36 (iv) Childbirth, child rearing, parenting, and stepparenting.
- 37 (v) Marriage, divorce, and blended families.
- 38 (vi) Long-term care.
- 39 (vii) End of life and grief.
- 40 (viii) Poverty and deprivation.

- 1 (ix) Financial and social stress.
- 2 (x) Effects of trauma.
- 3 (xi) The psychological, psychotherapeutic, community, and
- 4 health implications of the matters and life events described in
- 5 clauses (i) to (x), inclusive.
- 6 (D) Cultural competency and sensitivity, including a familiarity
- 7 with the racial, cultural, linguistic, and ethnic backgrounds of
- 8 persons living in California.
- 9 (E) Multicultural development and cross-cultural interaction,
- 10 including experiences of race, ethnicity, class, spirituality, sexual
- 11 orientation, gender, and disability, and their incorporation into the
- 12 psychotherapeutic process.
- 13 (F) The effects of socioeconomic status on treatment and
- 14 available resources.
- 15 (G) Resilience, including the personal and community qualities
- 16 that enable persons to cope with adversity, trauma, tragedy, threats,
- 17 or other stresses.
- 18 (H) Human sexuality, including the study of physiological,
- 19 psychological, and social cultural variables associated with sexual
- 20 behavior and gender identity, and the assessment and treatment of
- 21 psychosexual dysfunction.
- 22 (I) Substance use disorders, co-occurring disorders, and
- 23 addiction, including, but not limited to, instruction in all of the
- 24 following:
  - 25 (i) The definition of substance use disorders, co-occurring
  - 26 disorders, and addiction. For purposes of this subparagraph,
  - 27 “co-occurring disorders” means a mental illness and substance
  - 28 abuse diagnosis occurring simultaneously in an individual.
  - 29 (ii) Medical aspects of substance use disorders and co-occurring
  - 30 disorders.
  - 31 (iii) The effects of psychoactive drug use.
  - 32 (iv) Current theories of the etiology of substance abuse and
  - 33 addiction.
  - 34 (v) The role of persons and systems that support or compound
  - 35 substance abuse and addiction.
  - 36 (vi) Major approaches to identification, evaluation, and treatment
  - 37 of substance use disorders, co-occurring disorders, and addiction,
  - 38 including, but not limited to, best practices.
  - 39 (vii) Legal aspects of substance abuse.

- 1 (viii) Populations at risk with regard to substance use disorders  
2 and co-occurring disorders.
- 3 (ix) Community resources offering screening, assessment,  
4 treatment, and followup for the affected person and family.
- 5 (x) Recognition of substance use disorders, co-occurring  
6 disorders, and addiction, and appropriate referral.
- 7 (xi) The prevention of substance use disorders and addiction.
- 8 (J) California law and professional ethics for marriage and  
9 family therapists, including instruction in all of the following areas  
10 of study:
- 11 (i) Contemporary professional ethics and statutory, regulatory,  
12 and decisional laws that delineate the scope of practice of marriage  
13 and family therapy.
- 14 (ii) The therapeutic, clinical, and practical considerations  
15 involved in the legal and ethical practice of marriage and family  
16 therapy, including, but not limited to, family law.
- 17 (iii) The current legal patterns and trends in the mental health  
18 professions.
- 19 (iv) The psychotherapist-patient privilege, confidentiality, the  
20 patient dangerous to self or others, and the treatment of minors  
21 with and without parental consent.
- 22 (v) A recognition and exploration of the relationship between  
23 a practitioner's sense of self and human values and his or her  
24 professional behavior and ethics.
- 25 (vi) Differences in legal and ethical standards for different types  
26 of work settings.
- 27 (vii) Licensing law and licensing process.
- 28 (e) The degree described in subdivision (b) shall, in addition to  
29 meeting the requirements of subdivision (d), include instruction  
30 in case management, systems of care for the severely mentally ill,  
31 public and private services and supports available for the severely  
32 mentally ill, community resources for persons with mental illness  
33 and for victims of abuse, disaster and trauma response, advocacy  
34 for the severely mentally ill, and collaborative treatment. This  
35 instruction may be provided either in credit level coursework or  
36 through extension programs offered by the degree-granting  
37 institution.
- 38 (f) The changes made to law by this section are intended to  
39 improve the educational qualifications for licensure in order to  
40 better prepare future licentiates for practice, and are not intended

1 to expand or restrict the scope of practice for marriage and family  
2 therapists.

3 SEC. 9. Section 4980.37 of the Business and Professions Code  
4 is amended to read:

5 4980.37. (a) This section shall apply to applicants for licensure  
6 or registration who begin graduate study before August 1, 2012,  
7 and complete that study on or before December 31, 2018. Those  
8 applicants may alternatively qualify under paragraph (2) of  
9 subdivision (a) of Section 4980.36.

10 (b) To qualify for a license or registration, applicants shall  
11 possess a doctor's or master's degree in marriage, family, and child  
12 counseling, marriage and family therapy, couple and family  
13 therapy, psychology, clinical psychology, counseling psychology,  
14 or counseling with an emphasis in either marriage, family, and  
15 child counseling or marriage and family therapy, obtained from a  
16 school, college, or university accredited by a regional *or national*  
17 *institutional* accrediting agency that is recognized by the United  
18 States Department of Education or approved by the Bureau for  
19 Private Postsecondary Education. The board has the authority to  
20 make the final determination as to whether a degree meets all  
21 requirements, including, but not limited to, course requirements,  
22 regardless of accreditation or approval. In order to qualify for  
23 licensure pursuant to this section, a doctor's or master's degree  
24 program shall be a single, integrated program primarily designed  
25 to train marriage and family therapists and shall contain no less  
26 than 48 semester or 72 quarter units of instruction. This instruction  
27 shall include no less than 12 semester units or 18 quarter units of  
28 coursework in the areas of marriage, family, and child counseling,  
29 and marital and family systems approaches to treatment. The  
30 coursework shall include all of the following areas:

31 (1) The salient theories of a variety of psychotherapeutic  
32 orientations directly related to marriage and family therapy, and  
33 marital and family systems approaches to treatment.

34 (2) Theories of marriage and family therapy and how they can  
35 be utilized in order to intervene therapeutically with couples,  
36 families, adults, children, and groups.

37 (3) Developmental issues and life events from infancy to old  
38 age and their effect on individuals, couples, and family  
39 relationships. This may include coursework that focuses on specific  
40 family life events and the psychological, psychotherapeutic, and



1 health implications that arise within couples and families,  
2 including, but not limited to, childbirth, child rearing, childhood,  
3 adolescence, adulthood, marriage, divorce, blended families,  
4 stepparenting, abuse and neglect of older and dependent adults,  
5 and geropsychology.

6 (4) A variety of approaches to the treatment of children.

7 The board shall, by regulation, set forth the subjects of instruction  
8 required in this subdivision.

9 (c) (1) In addition to the 12 semester or 18 quarter units of  
10 coursework specified in subdivision (b), the doctor's or master's  
11 degree program shall contain not less than six semester or nine  
12 quarter units of supervised practicum in applied psychotherapeutic  
13 technique, assessments, diagnosis, prognosis, and treatment of  
14 premarital, couple, family, and child relationships, including  
15 dysfunctions, healthy functioning, health promotion, and illness  
16 prevention, in a supervised clinical placement that provides  
17 supervised fieldwork experience within the scope of practice of a  
18 marriage and family therapist.

19 (2) For applicants who enrolled in a degree program on or after  
20 January 1, 1995, the practicum shall include a minimum of 150  
21 hours of face-to-face experience counseling individuals, couples,  
22 families, or groups.

23 (3) The practicum hours shall be considered as part of the 48  
24 semester or 72 quarter unit requirement.

25 (d) As an alternative to meeting the qualifications specified in  
26 subdivision (b), the board shall accept as equivalent degrees those  
27 master's or doctor's degrees granted by educational institutions  
28 whose degree program is approved by the Commission on  
29 Accreditation for Marriage and Family Therapy Education.

30 (e) In order to provide an integrated course of study and  
31 appropriate professional training, while allowing for innovation  
32 and individuality in the education of marriage and family therapists,  
33 a degree program that meets the educational qualifications for  
34 licensure or registration under this section shall do all of the  
35 following:

36 (1) Provide an integrated course of study that trains students  
37 generally in the diagnosis, assessment, prognosis, and treatment  
38 of mental disorders.

39 (2) Prepare students to be familiar with the broad range of  
40 matters that may arise within marriage and family relationships.

1 (3) Train students specifically in the application of marriage  
2 and family relationship counseling principles and methods.

3 (4) Encourage students to develop those personal qualities that  
4 are intimately related to the counseling situation such as integrity,  
5 sensitivity, flexibility, insight, compassion, and personal presence.

6 (5) Teach students a variety of effective psychotherapeutic  
7 techniques and modalities that may be utilized to improve, restore,  
8 or maintain healthy individual, couple, and family relationships.

9 (6) Permit an emphasis or specialization that may address any  
10 one or more of the unique and complex array of human problems,  
11 symptoms, and needs of Californians served by marriage and  
12 family therapists.

13 (7) Prepare students to be familiar with cross-cultural mores  
14 and values, including a familiarity with the wide range of racial  
15 and ethnic backgrounds common among California's population,  
16 including, but not limited to, Blacks, Hispanics, Asians, and Native  
17 Americans.

18 (f) Educational institutions are encouraged to design the  
19 practicum required by this section to include marriage and family  
20 therapy experience in low income and multicultural mental health  
21 settings.

22 (g) This section shall remain in effect only until January 1, 2019,  
23 and as of that date is repealed, unless a later enacted statute, that  
24 is enacted before January 1, 2019, deletes or extends that date.

25 SEC. 10. Section 4980.40.5 of the Business and Professions  
26 Code is repealed.

27 ~~4980.40.5. (a) A doctoral or master's degree in marriage,~~  
28 ~~family, and child counseling, marital and family therapy, couple~~  
29 ~~and family therapy, psychology, clinical psychology, counseling~~  
30 ~~psychology, or counseling with an emphasis in either marriage,~~  
31 ~~family, and child counseling, or marriage and family therapy,~~  
32 ~~obtained from a school, college, or university approved by the~~  
33 ~~Bureau for Private Postsecondary Education as of June 30, 2007,~~  
34 ~~shall be considered by the board to meet the requirements necessary~~  
35 ~~for licensure as a marriage and family therapist and for registration~~  
36 ~~as a marriage and family therapist intern provided that the degree~~  
37 ~~is conferred on or before July 1, 2010.~~

38 ~~(b) As an alternative to meeting the qualifications specified in~~  
39 ~~subdivision (a) of Section 4980.40, the board shall accept as~~  
40 ~~equivalent degrees those doctoral or master's degrees that otherwise~~

1 ~~meet the requirements of this chapter and are conferred by~~  
2 ~~educational institutions accredited by any of the following~~  
3 ~~associations:~~  
4 ~~(1) Northwest Commission on Colleges and Universities.~~  
5 ~~(2) Middle States Association of Colleges and Secondary~~  
6 ~~Schools.~~  
7 ~~(3) New England Association of Schools and Colleges.~~  
8 ~~(4) North Central Association of Colleges and Secondary~~  
9 ~~Schools.~~  
10 ~~(5) Southern Association of Colleges and Schools.~~  
11 SEC. 11. Section 4980.43 of the Business and Professions  
12 Code is amended to read:  
13 4980.43. (a) To qualify for licensure as specified in Section  
14 4980.40, each applicant shall complete experience related to the  
15 practice of marriage and family therapy under a supervisor who  
16 meets the qualifications set forth in Section 4980.03. The  
17 experience shall comply with the following:  
18 (1) A minimum of 3,000 hours of supervised experience  
19 completed during a period of at least 104 weeks.  
20 (2) A maximum of 40 hours in any seven consecutive days.  
21 (3) A minimum of 1,700 hours obtained after the qualifying  
22 master's or doctoral degree was awarded.  
23 (4) A maximum of 1,300 hours obtained prior to the award date  
24 of the qualifying master's or doctoral degree.  
25 (5) A maximum of 750 hours of counseling and direct supervisor  
26 contact prior to the award date of the qualifying master's or  
27 doctoral degree.  
28 (6) No hours of experience may be gained prior to completing  
29 either 12 semester units or 18 quarter units of graduate instruction.  
30 (7) No hours of experience may be gained more than six years  
31 prior to the date the application for examination eligibility was  
32 filed, except that up to 500 hours of clinical experience gained in  
33 the supervised practicum required by subdivision (c) of Section  
34 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d)  
35 of Section 4980.36 shall be exempt from this six-year requirement.  
36 (8) A minimum of 1,750 hours of direct counseling with  
37 individuals, groups, couples, or families, that includes not less than  
38 500 total hours of experience in diagnosing and treating couples,  
39 families, and children.

1 (9) A maximum of 1,250 hours of nonclinical practice,  
2 consisting of direct supervisor contact, administering and  
3 evaluating psychological tests, writing clinical reports, writing  
4 progress or process notes, client centered advocacy, and workshops,  
5 seminars, training sessions, or conferences directly related to  
6 marriage and family therapy that have been approved by the  
7 applicant's supervisor.

8 (10) It is anticipated and encouraged that hours of experience  
9 will include working with elders and dependent adults who have  
10 physical or mental limitations that restrict their ability to carry out  
11 normal activities or protect their rights.

12 This subdivision shall only apply to hours gained on and after  
13 January 1, 2010.

14 (b) An individual who submits an application for examination  
15 eligibility between January 1, 2016, and December 31, 2020, may  
16 alternatively qualify under the experience requirements that were  
17 in place on January 1, 2015.

18 (c) All applicants, trainees, and registrants shall be at all times  
19 under the supervision of a supervisor who shall be responsible for  
20 ensuring that the extent, kind, and quality of counseling performed  
21 is consistent with the training and experience of the person being  
22 supervised, and who shall be responsible to the board for  
23 compliance with all laws, rules, and regulations governing the  
24 practice of marriage and family therapy. Supervised experience  
25 shall be gained by an intern or trainee only as an employee or as  
26 a volunteer. The requirements of this chapter regarding gaining  
27 hours of experience and supervision are applicable equally to  
28 employees and volunteers. ~~Experience shall not be gained by an~~  
29 ~~intern or trainee as an independent contractor. Associates and~~  
30 ~~trainees shall not be employed as independent contractors, and~~  
31 ~~shall not gain experience for work performed as an independent~~  
32 ~~contractor, reported on an IRS Form 1099, or both.~~

33 (1) If employed, an intern shall provide the board with copies  
34 of the corresponding W-2 tax forms for each year of experience  
35 claimed upon application for licensure.

36 (2) If volunteering, an intern shall provide the board with a letter  
37 from his or her employer verifying the intern's employment as a  
38 volunteer upon application for licensure.

39 (d) Except for experience gained by attending workshops,  
40 seminars, training sessions, or conferences as described in

1 paragraph (9) of subdivision (a), supervision shall include at least  
2 one hour of direct supervisor contact in each week for which  
3 experience is credited in each work setting, as specified:

4 (1) A trainee shall receive an average of at least one hour of  
5 direct supervisor contact for every five hours of client contact in  
6 each setting. No more than six hours of supervision, whether  
7 individual or group, shall be credited during any single week.

8 (2) An individual supervised after being granted a qualifying  
9 degree shall receive at least one additional hour of direct supervisor  
10 contact for every week in which more than 10 hours of client  
11 contact is gained in each setting. No more than six hours of  
12 supervision, whether individual or group, shall be credited during  
13 any single week.

14 (3) For purposes of this section, “one hour of direct supervisor  
15 contact” means one hour per week of face-to-face contact on an  
16 individual basis or two hours per week of face-to-face contact in  
17 a group.

18 (4) Direct supervisor contact shall occur within the same week  
19 as the hours claimed.

20 (5) Direct supervisor contact provided in a group shall be  
21 provided in a group of not more than eight supervisees and in  
22 segments lasting no less than one continuous hour.

23 (6) Notwithstanding paragraph (3), an intern working in a  
24 governmental entity, a school, a college, or a university, or an  
25 institution that is both nonprofit and charitable may obtain the  
26 required weekly direct supervisor contact via two-way, real-time  
27 videoconferencing. The supervisor shall be responsible for ensuring  
28 that client confidentiality is upheld.

29 (7) All experience gained by a trainee shall be monitored by the  
30 supervisor as specified by regulation.

31 (8) The six hours of supervision that may be credited during  
32 any single week pursuant to paragraphs (1) and (2) shall apply to  
33 supervision hours gained on or after January 1, 2009.

34 (e) (1) A trainee may be credited with supervised experience  
35 completed in any setting that meets all of the following:

36 (A) Lawfully and regularly provides mental health counseling  
37 or psychotherapy.

38 (B) Provides oversight to ensure that the trainee’s work at the  
39 setting meets the experience and supervision requirements set forth

1 in this chapter and is within the scope of practice for the profession  
2 as defined in Section 4980.02.

3 (C) Is not a private practice owned by a licensed marriage and  
4 family therapist, a licensed professional clinical counselor, a  
5 licensed psychologist, a licensed clinical social worker, a licensed  
6 physician and surgeon, or a professional corporation of any of  
7 those licensed professions.

8 (2) Experience may be gained by the trainee solely as part of  
9 the position for which the trainee volunteers or is employed.

10 (f) (1) An intern may be credited with supervised experience  
11 completed in any setting that meets both of the following:

12 (A) Lawfully and regularly provides mental health counseling  
13 or psychotherapy.

14 (B) Provides oversight to ensure that the intern's work at the  
15 setting meets the experience and supervision requirements set forth  
16 in this chapter and is within the scope of practice for the profession  
17 as defined in Section 4980.02.

18 (2) An applicant shall not be employed or volunteer in a private  
19 practice, as defined in subparagraph (C) of paragraph (1) of  
20 subdivision (e), until registered as an intern.

21 (3) While an intern may be either a paid employee or a  
22 volunteer, employers are encouraged to provide fair remuneration  
23 to interns.

24 (4) Except for periods of time during a supervisor's vacation or  
25 sick leave, an intern who is employed or volunteering in private  
26 practice shall be under the direct supervision of a licensee that has  
27 satisfied subdivision (g) of Section 4980.03. The supervising  
28 licensee shall either be employed by and practice at the same site  
29 as the intern's employer, or shall be an owner or shareholder of  
30 the private practice. Alternative supervision may be arranged during  
31 a supervisor's vacation or sick leave if the supervision meets the  
32 requirements of this section.

33 (5) Experience may be gained by the intern solely as part of the  
34 position for which the intern volunteers or is employed.

35 (g) Except as provided in subdivision (h), all persons shall  
36 register with the board as an intern to be credited for postdegree  
37 hours of supervised experience gained toward licensure.

38 (h) Postdegree hours of experience shall be credited toward  
39 licensure so long as the applicant applies for the intern registration  
40 within 90 days of the granting of the qualifying master's or doctoral

1 degree and is thereafter granted the intern registration by the board.  
2 An applicant shall not be employed or volunteer in a private  
3 practice until registered as an intern by the board.

4 (i) Trainees, interns, and applicants shall not receive any  
5 remuneration from patients or clients, and shall only be paid by  
6 their employers.

7 (j) Trainees, interns, and applicants shall only perform services  
8 at the place where their employers regularly conduct business,  
9 which may include performing services at other locations, so long  
10 as the services are performed under the direction and control of  
11 their employer and supervisor, and in compliance with the laws  
12 and regulations pertaining to supervision. For purposes of  
13 paragraph (3) of subdivision (a) of Section 2290.5, interns and  
14 trainees working under licensed supervision, consistent with  
15 subdivision (c), may provide services via telehealth within the  
16 scope authorized by this chapter and in accordance with any  
17 regulations governing the use of telehealth promulgated by the  
18 board. Trainees and interns shall have no proprietary interest in  
19 their employers' businesses and shall not lease or rent space, pay  
20 for furnishings, equipment, or supplies, or in any other way pay  
21 for the obligations of their employers.

22 (k) Trainees, interns, or applicants who provide volunteered  
23 services or other services, and who receive no more than a total,  
24 from all work settings, of five hundred dollars (\$500) per month  
25 as reimbursement for expenses actually incurred by those trainees,  
26 interns, or applicants for services rendered in any lawful work  
27 setting other than a private practice shall be considered employees  
28 and not independent contractors. The board may audit applicants  
29 who receive reimbursement for expenses, and the applicants shall  
30 have the burden of demonstrating that the payments received were  
31 for reimbursement of expenses actually incurred.

32 (l) Each educational institution preparing applicants for licensure  
33 pursuant to this chapter shall consider requiring, and shall  
34 encourage, its students to undergo individual, marital or conjoint,  
35 family, or group counseling or psychotherapy, as appropriate. Each  
36 supervisor shall consider, advise, and encourage his or her interns  
37 and trainees regarding the advisability of undertaking individual,  
38 marital or conjoint, family, or group counseling or psychotherapy,  
39 as appropriate. Insofar as it is deemed appropriate and is desired  
40 by the applicant, the educational institution and supervisors are

1 encouraged to assist the applicant in locating that counseling or  
2 psychotherapy at a reasonable cost.

3 SEC. 12. Section 4980.78 of the Business and Professions  
4 Code is amended to read:

5 4980.78. (a) This section applies to persons who apply for  
6 licensure or registration on or after January 1, 2016, and who do  
7 not hold a license as described in Section 4980.72.

8 (b) For purposes of Section 4980.74, education is substantially  
9 equivalent if all of the following requirements are met:

10 (1) The degree is obtained from a school, college, or university  
11 accredited by ~~an~~ *a regional or national institutional* accrediting  
12 agency that is recognized by the United States Department of  
13 Education and consists of, at a minimum, the following:

14 (A) (i) For an applicant who obtained his or her degree within  
15 the timeline prescribed by subdivision (a) of Section 4980.36, the  
16 degree shall contain no less than 60 semester or 90 quarter units  
17 of instruction.

18 (ii) Up to 12 semester or 18 quarter units of instruction may be  
19 remediated, if missing from the degree. The remediation may occur  
20 while the applicant is registered as an intern.

21 (B) For an applicant who obtained his or her degree within the  
22 timeline prescribed by subdivision (a) of Section 4980.37, the  
23 degree shall contain no less than 48 semester units or 72 quarter  
24 units of instruction.

25 (C) Six semester or nine quarter units of practicum, including,  
26 but not limited to, a minimum of 150 hours of face-to-face  
27 counseling, and an additional 75 hours of either face-to-face  
28 counseling or client-centered advocacy, or a combination of  
29 face-to-face counseling and client-centered advocacy.

30 (D) Twelve semester or 18 quarter units in the areas of marriage,  
31 family, and child counseling and marital and family systems  
32 approaches to treatment, as specified in subparagraph (A) of  
33 paragraph (1) of subdivision (d) of Section 4980.36.

34 (2) The applicant shall complete coursework in California law  
35 and ethics as follows:

36 (A) An applicant who completed a course in law and  
37 professional ethics for marriage and family therapists as specified  
38 in paragraph (7) of subdivision (a) of Section 4980.81, that did not  
39 contain instruction in California law and ethics, shall complete an  
40 18-hour course in California law and professional ethics. The



1 content of the course shall include, but not be limited to,  
2 advertising, scope of practice, scope of competence, treatment of  
3 minors, confidentiality, dangerous patients, psychotherapist-patient  
4 privilege, recordkeeping, patient access to records, state and federal  
5 laws relating to confidentiality of patient health information, dual  
6 relationships, child abuse, elder and dependent adult abuse, online  
7 therapy, insurance reimbursement, civil liability, disciplinary  
8 actions and unprofessional conduct, ethics complaints and ethical  
9 standards, termination of therapy, standards of care, relevant family  
10 law, therapist disclosures to patients, differences in legal and ethical  
11 standards in different types of work settings, and licensing law  
12 and licensing process. This coursework shall be completed prior  
13 to registration as an intern.

14 (B) An applicant who has not completed a course in law and  
15 professional ethics for marriage and family therapists as specified  
16 in paragraph (7) of subdivision (a) of Section 4980.81 shall  
17 complete this required coursework. The coursework shall contain  
18 content specific to California law and ethics. This coursework shall  
19 be completed prior to registration as an intern.

20 (3) The applicant completes the educational requirements  
21 specified in Section 4980.81 not already completed in his or her  
22 education. The coursework may be from an accredited school,  
23 college, or university as specified in paragraph (1), from an  
24 educational institution approved by the Bureau for Private  
25 Postsecondary Education, or from a continuing education provider  
26 that is acceptable to the board as defined in Section 4980.54.  
27 Undergraduate courses shall not satisfy this requirement.

28 (4) The applicant completes the following coursework not  
29 already completed in his or her education from an accredited  
30 school, college, or university as specified in paragraph (1) from  
31 an educational institution approved by the Bureau for Private  
32 Postsecondary Education, or from a continuing education provider  
33 that is acceptable to the board as defined in Section 4980.54.  
34 Undergraduate courses shall not satisfy this requirement.

35 (A) At least three semester units, or 45 hours, of instruction  
36 regarding the principles of mental health recovery-oriented care  
37 and methods of service delivery in recovery-oriented practice  
38 environments, including structured meetings with various  
39 consumers and family members of consumers of mental health

1 services to enhance understanding of their experience of mental  
2 illness, treatment, and recovery.

3 (B) At least one semester unit, or 15 hours, of instruction that  
4 includes an understanding of various California cultures and the  
5 social and psychological implications of socioeconomic position.

6 (5) An applicant may complete any units and course content  
7 requirements required under paragraphs (3) and (4) not already  
8 completed in his or her education while registered as an intern,  
9 unless otherwise specified.

10 (6) The applicant's degree title need not be identical to that  
11 required by subdivision (b) of Section 4980.36.

12 SEC. 13. Section 4980.79 of the Business and Professions  
13 Code is amended to read:

14 4980.79. (a) This section applies to persons who apply for  
15 licensure or registration on or after January 1, 2016, and who hold  
16 a license as described in Section 4980.72.

17 (b) For purposes of Section 4980.72, education is substantially  
18 equivalent if all of the following requirements are met:

19 (1) The degree is obtained from a school, college, or university  
20 accredited by ~~an~~ *a regional or national institutional* accrediting  
21 agency recognized by the United States Department of Education  
22 and consists of, at a minimum, the following:

23 (A) (i) For an applicant who obtained his or her degree within  
24 the timeline prescribed by subdivision (a) of Section 4980.36, the  
25 degree shall contain no less than 60 semester or 90 quarter units  
26 of instruction.

27 (ii) Up to 12 semester or 18 quarter units of instruction may be  
28 remediated, if missing from the degree. The remediation may occur  
29 while the applicant is registered as an intern.

30 (B) For an applicant who obtained his or her degree within the  
31 timeline prescribed by subdivision (a) of Section 4980.37, the  
32 degree shall contain no less than 48 semester or 72 quarter units  
33 of instruction.

34 (C) Six semester or nine quarter units of practicum, including,  
35 but not limited to, a minimum of 150 hours of face-to-face  
36 counseling, and an additional 75 hours of either face-to-face  
37 counseling or client-centered advocacy, or a combination of  
38 face-to-face counseling and client-centered advocacy.

1 (i) An out-of-state applicant who has been licensed for at least  
2 two years in clinical practice, as verified by the board, is exempt  
3 from this requirement.

4 (ii) An out-of-state applicant who has been licensed for less  
5 than two years in clinical practice, as verified by the board, who  
6 does not meet the practicum requirement, shall remediate it by  
7 obtaining 150 hours of face-to-face counseling, and an additional  
8 75 hours of either face-to-face counseling or client-centered  
9 advocacy, or a combination of face-to-face counseling and  
10 client-centered advocacy. These hours are in addition to the 3,000  
11 hours of experience required by this chapter, and shall be gained  
12 while registered as an intern.

13 (D) Twelve semester or 18 quarter units in the areas of marriage,  
14 family, and child counseling and marital and family systems  
15 approaches to treatment, as specified in subparagraph (A) of  
16 paragraph (1) of subdivision (d) of Section 4980.36.

17 (2) An applicant shall complete coursework in California law  
18 and ethics as follows:

19 (A) An applicant who completed a course in law and  
20 professional ethics for marriage and family therapists as specified  
21 in paragraph (7) of subdivision (a) of Section 4980.81 that did not  
22 include instruction in California law and ethics, shall complete an  
23 18-hour course in California law and professional ethics. The  
24 content of the course shall include, but not be limited to,  
25 advertising, scope of practice, scope of competence, treatment of  
26 minors, confidentiality, dangerous patients, psychotherapist-patient  
27 privilege, recordkeeping, patient access to records, state and federal  
28 laws relating to confidentiality of patient health information, dual  
29 relationships, child abuse, elder and dependent adult abuse, online  
30 therapy, insurance reimbursement, civil liability, disciplinary  
31 actions and unprofessional conduct, ethics complaints and ethical  
32 standards, termination of therapy, standards of care, relevant family  
33 law, therapist disclosures to patients, differences in legal and ethical  
34 standards in different types of work settings, and licensing law  
35 and licensing process. This coursework shall be completed prior  
36 to registration as an intern.

37 (B) An applicant who has not completed a course in law and  
38 professional ethics for marriage and family therapists as specified  
39 in paragraph (7) of subdivision (a) of Section 4980.81 shall  
40 complete this required coursework. The coursework shall include

1 content specific to California law and ethics. An applicant shall  
2 complete this coursework prior to registration as an intern.

3 (3) The applicant completes the educational requirements  
4 specified in Section 4980.81 not already completed in his or her  
5 education. The coursework may be from an accredited school,  
6 college, or university as specified in paragraph (1), from an  
7 educational institution approved by the Bureau for Private  
8 Postsecondary Education, or from a continuing education provider  
9 that is acceptable to the board as defined in Section 4980.54.  
10 Undergraduate coursework shall not satisfy this requirement.

11 (4) The applicant completes the following coursework not  
12 already completed in his or her education from an accredited  
13 school, college, or university as specified in paragraph (1) above,  
14 from an educational institution approved by the Bureau for Private  
15 Postsecondary Education, or from a continuing education provider  
16 that is acceptable to the board as defined in Section 4980.54.  
17 Undergraduate coursework shall not satisfy this requirement.

18 (A) At least three semester units, or 45 hours, of instruction  
19 pertaining to the principles of mental health recovery-oriented care  
20 and methods of service delivery in recovery-oriented practice  
21 environments, including structured meetings with various  
22 consumers and family members of consumers of mental health  
23 services to enhance understanding of their experience of mental  
24 illness, treatment, and recovery.

25 (B) At least one semester unit, or 15 hours, of instruction that  
26 includes an understanding of various California cultures and the  
27 social and psychological implications of socioeconomic position.

28 (5) An applicant's degree title need not be identical to that  
29 required by subdivision (b) of Section 4980.36.

30 (6) An applicant may complete any units and course content  
31 requirements required under paragraphs (3) and (4) not already  
32 completed in his or her education while registered as an intern,  
33 unless otherwise specified.

34 SEC. 14. Section 4992.05 of the Business and Professions  
35 Code is amended to read:

36 4992.05. (a) Effective January 1, 2016, an applicant for  
37 licensure as a clinical social worker shall pass the following two  
38 examinations as prescribed by the board:

39 (1) A California law and ethics examination.

40 (2) A clinical examination.

1 (b) Upon registration with the board, an associate *clinical* social  
2 worker registrant shall, within the first year of registration, take  
3 an examination on California law and ethics.

4 (c) A registrant may take the clinical examination only upon  
5 meeting all of the following requirements:

- 6 (1) Completion of all education requirements.
- 7 (2) Passage of the California law and ethics examination.
- 8 (3) Completion of all required supervised work experience.

9 (d) This section shall become operative on January 1, 2016.

10 SEC. 15. Section 4996.18 of the Business and Professions  
11 Code is amended to read:

12 4996.18. (a) A person who wishes to be credited with  
13 experience toward licensure requirements shall register with the  
14 board as an associate clinical social worker prior to obtaining that  
15 experience. The application shall be made on a form prescribed  
16 by the board.

17 (b) An applicant for registration shall satisfy the following  
18 requirements:

19 (1) Possess a master’s degree from an accredited school or  
20 department of social work.

21 (2) Have committed no crimes or acts constituting grounds for  
22 denial of licensure under Section 480.

23 (3) Commencing January 1, 2014, have completed training or  
24 coursework, which may be embedded within more than one course,  
25 in California law and professional ethics for clinical social workers,  
26 including instruction in all of the following areas of study:

27 (A) Contemporary professional ethics and statutes, regulations,  
28 and court decisions that delineate the scope of practice of clinical  
29 social work.

30 (B) The therapeutic, clinical, and practical considerations  
31 involved in the legal and ethical practice of clinical social work,  
32 including, but not limited to, family law.

33 (C) The current legal patterns and trends in the mental health  
34 professions.

35 (D) The psychotherapist-patient privilege, confidentiality,  
36 dangerous patients, and the treatment of minors with and without  
37 parental consent.

38 (E) A recognition and exploration of the relationship between  
39 a practitioner’s sense of self and human values, and his or her  
40 professional behavior and ethics.

1 (F) Differences in legal and ethical standards for different types  
2 of work settings.

3 (G) Licensing law and process.

4 (c) An applicant who possesses a master's degree from a school  
5 or department of social work that is a candidate for accreditation  
6 by the Commission on Accreditation of the Council on Social  
7 Work Education shall be eligible, and shall be required, to register  
8 as an associate clinical social worker in order to gain experience  
9 toward licensure if the applicant has not committed any crimes or  
10 acts that constitute grounds for denial of licensure under Section  
11 480. That applicant shall not, however, be eligible ~~for~~ *to take the*  
12 *clinical* examination until the school or department of social work  
13 has received accreditation by the Commission on Accreditation  
14 of the Council on Social Work Education.

15 (d) All applicants and registrants shall be at all times under the  
16 supervision of a supervisor who shall be responsible for ensuring  
17 that the extent, kind, and quality of counseling performed is  
18 consistent with the training and experience of the person being  
19 supervised, and who shall be responsible to the board for  
20 compliance with all laws, rules, and regulations governing the  
21 practice of clinical social work.

22 (e) Any experience obtained under the supervision of a spouse  
23 or relative by blood or marriage shall not be credited toward the  
24 required hours of supervised experience. Any experience obtained  
25 under the supervision of a supervisor with whom the applicant has  
26 a personal relationship that undermines the authority or  
27 effectiveness of the supervision shall not be credited toward the  
28 required hours of supervised experience.

29 (f) An applicant who possesses a master's degree from an  
30 accredited school or department of social work shall be able to  
31 apply experience the applicant obtained during the time the  
32 accredited school or department was in candidacy status by the  
33 Commission on Accreditation of the Council on Social Work  
34 Education toward the licensure requirements, if the experience  
35 meets the requirements of Section 4996.23. This subdivision shall  
36 apply retroactively to persons who possess a master's degree from  
37 an accredited school or department of social work and who  
38 obtained experience during the time the accredited school or  
39 department was in candidacy status by the Commission on  
40 Accreditation of the Council on Social Work Education.

1 (g) An applicant for registration or licensure trained in an  
2 educational institution outside the United States shall demonstrate  
3 to the satisfaction of the board that he or she possesses a master’s  
4 of social work degree that is equivalent to a master’s degree issued  
5 from a school or department of social work that is accredited by  
6 the Commission on Accreditation of the Council on Social Work  
7 Education. These applicants shall provide the board with a  
8 comprehensive evaluation of the degree and shall provide any  
9 other documentation the board deems necessary. The board has  
10 the authority to make the final determination as to whether a degree  
11 meets all requirements, including, but not limited to, course  
12 requirements regardless of evaluation or accreditation.

13 (h) A registrant shall not provide clinical social work services  
14 to the public for a fee, monetary or otherwise, except as an  
15 employee.

16 (i) A registrant shall inform each client or patient prior to  
17 performing any professional services that he or she is unlicensed  
18 and is under the supervision of a licensed professional.

19 SEC. 16. Section 4996.23 of the Business and Professions  
20 Code is amended to read:

21 4996.23. (a) To qualify for licensure as specified in Section  
22 4996.2, each applicant shall complete 3,200 hours of post-master’s  
23 degree supervised experience related to the practice of clinical  
24 social work. The experience shall comply with the following:

25 (1) At least 1,700 hours shall be gained under the supervision  
26 of a licensed clinical social worker. The remaining required  
27 supervised experience may be gained under the supervision of a  
28 licensed mental health professional acceptable to the board as  
29 defined by a regulation adopted by the board.

30 (2) A minimum of 2,000 hours in clinical psychosocial  
31 diagnosis, assessment, and treatment, including psychotherapy or  
32 counseling.

33 (3) A maximum of 1,200 hours in client centered advocacy,  
34 consultation, evaluation, research, direct supervisor contact, and  
35 workshops, seminars, training sessions, or conferences directly  
36 related to clinical social work that have been approved by the  
37 applicant’s supervisor.

38 (4) Of the 2,000 clinical hours required in paragraph (2), no less  
39 than 750 hours shall be face-to-face individual or group

1 psychotherapy provided to clients in the context of clinical social  
2 work services.

3 (5) A minimum of two years of supervised experience is required  
4 to be obtained over a period of not less than 104 weeks and shall  
5 have been gained within the six years immediately preceding the  
6 date on which the application for licensure was filed.

7 (6) Experience shall not be credited for more than 40 hours in  
8 any week.

9 (b) An individual who submits an application for examination  
10 eligibility between January 1, 2016, and December 31, 2020, may  
11 alternatively qualify under the experience requirements that were  
12 in place on January 1, 2015.

13 (c) “Supervision” means responsibility for, and control of, the  
14 quality of clinical social work services being provided.  
15 Consultation or peer discussion shall not be considered to be  
16 supervision.

17 (d) (1) Prior to the commencement of supervision, a supervisor  
18 shall comply with all requirements enumerated in Section 1870 of  
19 Title 16 of the California Code of Regulations and shall sign under  
20 penalty of perjury the “Responsibility Statement for Supervisors  
21 of an Associate Clinical Social Worker” form.

22 (2) Supervised experience shall include at least one hour of  
23 direct supervisor contact for a minimum of 104 weeks. For  
24 purposes of this subdivision, “one hour of direct supervisor contact”  
25 means one hour per week of face-to-face contact on an individual  
26 basis or two hours of face-to-face contact in a group conducted  
27 within the same week as the hours claimed.

28 (3) An associate shall receive at least one additional hour of  
29 direct supervisor contact for every week in which more than 10  
30 hours of face-to-face psychotherapy is performed in each setting  
31 in which experience is gained. No more than six hours of  
32 supervision, whether individual or group, shall be credited during  
33 any single week.

34 (4) Supervision shall include at least one hour of direct  
35 supervisor contact during each week for which experience is gained  
36 in each work setting. Supervision is not required for experience  
37 gained attending workshops, seminars, training sessions, or  
38 conferences as described in paragraph (3) of subdivision (a).



1 (5) The six hours of supervision that may be credited during  
2 any single week pursuant to paragraph (3) shall apply only to  
3 supervision hours gained on or after January 1, 2010.

4 (6) Group supervision shall be provided in a group of not more  
5 than eight supervisees and shall be provided in segments lasting  
6 no less than one continuous hour.

7 (7) Of the 104 weeks of required supervision, 52 weeks shall  
8 be individual supervision, and of the 52 weeks of required  
9 individual supervision, not less than 13 weeks shall be supervised  
10 by a licensed clinical social worker.

11 (8) Notwithstanding paragraph (2), an associate clinical social  
12 worker working for a governmental entity, school, college, or  
13 university, or an institution that is both a nonprofit and charitable  
14 institution, may obtain the required weekly direct supervisor  
15 contact via live two-way videoconferencing. The supervisor shall  
16 be responsible for ensuring that client confidentiality is preserved.

17 (e) The supervisor and the associate shall develop a supervisory  
18 plan that describes the goals and objectives of supervision. These  
19 goals shall include the ongoing assessment of strengths and  
20 limitations and the assurance of practice in accordance with the  
21 laws and regulations. The associate shall submit to the board the  
22 initial original supervisory plan upon application for licensure.

23 (f) Experience shall only be gained in a setting that meets both  
24 of the following:

25 (1) Lawfully and regularly provides clinical social work, mental  
26 health counseling, or psychotherapy.

27 (2) Provides oversight to ensure that the associate's work at the  
28 setting meets the experience and supervision requirements set forth  
29 in this chapter and is within the scope of practice for the profession  
30 as defined in Section 4996.9.

31 (g) Experience shall not be gained until the applicant has been  
32 registered as an associate clinical social worker.

33 (h) Employment in a private practice as defined in subdivision  
34 (i) shall not commence until the applicant has been registered as  
35 an associate clinical social worker.

36 (i) A private practice setting is a setting that is owned by a  
37 licensed clinical social worker, a licensed marriage and family  
38 therapist, a licensed psychologist, a licensed professional clinical  
39 counselor, a licensed physician and surgeon, or a professional  
40 corporation of any of those licensed professions.

1 (j) Associates shall not be employed as independent contractors,  
2 and shall not gain experience for work performed as an  
3 independent contractor, reported on an IRS Form 1099, or both.

4 ~~(j)~~

5 (k) If volunteering, the associate shall provide the board with a  
6 letter from his or her employer verifying his or her voluntary status  
7 upon application for licensure.

8 ~~(k)~~

9 (l) If employed, the associate shall provide the board with copies  
10 of his or her W-2 tax forms for each year of experience claimed  
11 upon application for licensure.

12 ~~(l)~~

13 (m) While an associate may be either a paid employee or  
14 volunteer, employers are encouraged to provide fair remuneration  
15 to associates.

16 ~~(m)~~

17 (n) An associate shall not do the following:

18 (1) Receive any remuneration from patients or clients and shall  
19 only be paid by his or her employer.

20 (2) Have any proprietary interest in the employer's business.

21 (3) Lease or rent space, pay for furnishings, equipment, or  
22 supplies, or in any other way pay for the obligations of his or her  
23 employer.

24 ~~(n)~~

25 (o) An associate, whether employed or volunteering, may obtain  
26 supervision from a person not employed by the associate's  
27 employer if that person has signed a written agreement with the  
28 employer to take supervisory responsibility for the associate's  
29 social work services.

30 ~~(o)~~

31 (p) Notwithstanding any other provision of law, associates and  
32 applicants for examination shall receive a minimum of one hour  
33 of supervision per week for each setting in which he or she is  
34 working.

35 SEC. 17. Section 4999.12 of the Business and Professions  
36 Code is amended to read:

37 4999.12. For purposes of this chapter, the following terms have  
38 the following meanings:

39 (a) "Board" means the Board of Behavioral Sciences.

1 (b) “Accredited” means a school, college, or university  
2 accredited by the ~~Western Association of Schools and Colleges,~~  
3 ~~or its equivalent regional accrediting association.~~ *a regional or*  
4 *national institutional accrediting agency that is recognized by the*  
5 *United States Department of Education.*

6 (c) “Approved” means a school, college, or university that  
7 possessed unconditional approval by the Bureau for Private  
8 Postsecondary Education at the time of the applicant’s graduation  
9 from the school, college, or university.

10 (d) “Applicant” means an unlicensed person who has completed  
11 a master’s or doctoral degree program, as specified in Section  
12 4999.32 or 4999.33, as applicable, and whose application for  
13 registration as an intern is pending or who has applied for  
14 examination eligibility, or an unlicensed person who has completed  
15 the requirements for licensure specified in this chapter and is no  
16 longer registered with the board as an intern.

17 (e) “Licensed professional clinical counselor” or “LPCC” means  
18 a person licensed under this chapter to practice professional clinical  
19 counseling, as defined in Section 4999.20.

20 (f) “Intern” means an unlicensed person who meets the  
21 requirements of Section 4999.42 and is registered with the board.

22 (g) “Clinical counselor trainee” means an unlicensed person  
23 who is currently enrolled in a master’s or doctoral degree program,  
24 as specified in Section 4999.32 or 4999.33, as applicable, that is  
25 designed to qualify him or her for licensure under this chapter, and  
26 who has completed no less than 12 semester units or 18 quarter  
27 units of coursework in any qualifying degree program.

28 (h) “Approved supervisor” means an individual who meets the  
29 following requirements:

30 (1) Has documented two years of clinical experience as a  
31 licensed professional clinical counselor, licensed marriage and  
32 family therapist, licensed clinical psychologist, licensed clinical  
33 social worker, or licensed physician and surgeon who is certified  
34 in psychiatry by the American Board of Psychiatry and Neurology.

35 (2) Has received professional training in supervision.

36 (3) Has not provided therapeutic services to the clinical  
37 counselor trainee or intern.

38 (4) Has a current and valid license that is not under suspension  
39 or probation.

1 (i) “Client centered advocacy” includes, but is not limited to,  
2 researching, identifying, and accessing resources, or other activities,  
3 related to obtaining or providing services and supports for clients  
4 or groups of clients receiving psychotherapy or counseling services.

5 (j) “Advertising” or “advertise” includes, but is not limited to,  
6 the issuance of any card, sign, or device to any person, or the  
7 causing, permitting, or allowing of any sign or marking on, or in,  
8 any building or structure, or in any newspaper or magazine or in  
9 any directory, or any printed matter whatsoever, with or without  
10 any limiting qualification. It also includes business solicitations  
11 communicated by radio or television broadcasting. Signs within  
12 church buildings or notices in church bulletins mailed to a  
13 congregation shall not be construed as advertising within the  
14 meaning of this chapter.

15 (k) “Referral” means evaluating and identifying the needs of a  
16 client to determine whether it is advisable to refer the client to  
17 other specialists, informing the client of that judgment, and  
18 communicating that determination as requested or deemed  
19 appropriate to referral sources.

20 (l) “Research” means a systematic effort to collect, analyze, and  
21 interpret quantitative and qualitative data that describes how social  
22 characteristics, behavior, emotion, cognitions, disabilities, mental  
23 disorders, and interpersonal transactions among individuals and  
24 organizations interact.

25 (m) “Supervision” includes the following:

26 (1) Ensuring that the extent, kind, and quality of counseling  
27 performed is consistent with the education, training, and experience  
28 of the person being supervised.

29 (2) Reviewing client or patient records, monitoring and  
30 evaluating assessment, diagnosis, and treatment decisions of the  
31 clinical counselor trainee.

32 (3) Monitoring and evaluating the ability of the intern or clinical  
33 counselor trainee to provide services to the particular clientele at  
34 the site or sites where he or she will be practicing.

35 (4) Ensuring compliance with laws and regulations governing  
36 the practice of licensed professional clinical counseling.

37 (5) That amount of direct observation, or review of audio or  
38 videotapes of counseling or therapy, as deemed appropriate by the  
39 supervisor.

1 SEC. 18. Section 4999.12.5 is added to the Business and  
2 Professions Code, to read:

3 4999.12.5. (a) The title “professional clinical counselor intern”  
4 or “professional clinical counselor registered intern” is hereby  
5 renamed “associate professional clinical counselor” or “registered  
6 associate professional clinical counselor,” respectively. Any  
7 reference in any statute or regulation to a “professional clinical  
8 counselor intern” or “professional clinical counselor registered  
9 intern” shall be deemed a reference to an “associate professional  
10 clinical counselor” or “registered associate professional clinical  
11 counselor.”

12 (b) Nothing in this section shall be construed to expand or  
13 constrict the scope of practice of a person licensed or registered  
14 pursuant to this chapter.

15 (c) This section shall become operative January 1, 2018.

16 SEC. 19. Section 4999.40 of the Business and Professions  
17 Code is amended to read:

18 4999.40. (a) Each educational institution preparing applicants  
19 to qualify for licensure shall notify each of its students by means  
20 of its public documents or otherwise in writing that its degree  
21 program is designed to meet the requirements of Section 4999.32  
22 or 4999.33 and shall certify to the board that it has so notified its  
23 students.

24 (b) *An applicant for registration or licensure shall submit to*  
25 *the board a certification by the applicant’s educational institution*  
26 *that the institution’s required curriculum for graduation and any*  
27 *associated coursework completed by the applicant does one of the*  
28 *following:*

29 (1) *Meets all of the requirements set forth in Section 4999.32.*

30 (2) *Meets all of the requirements set forth in Section 4999.33.*

31 ~~(b)~~

32 (c) An applicant trained at an educational institution outside the  
33 United States shall demonstrate to the satisfaction of the board  
34 that he or she possesses a qualifying degree that is equivalent to a  
35 degree earned from an institution of higher education that is  
36 accredited or approved. These applicants shall provide the board  
37 with a comprehensive evaluation of the degree performed by a  
38 foreign credential evaluation service that is a member of the  
39 National Association of Credential Evaluation Services and shall  
40 provide any other documentation the board deems necessary.

1 SEC. 20. Section 4999.47 of the Business and Professions  
2 Code is amended to read:

3 4999.47. (a) Clinical counselor trainees, interns, and applicants  
4 shall perform services only as an employee or as a volunteer.

5 The requirements of this chapter regarding gaining hours of  
6 clinical mental health experience and supervision are applicable  
7 equally to employees and volunteers. ~~Experience shall not be~~  
8 ~~gained by interns or trainees as an independent contractor.~~  
9 *Associates and trainees shall not be employed as independent*  
10 *contractors, and shall not gain experience for work performed as*  
11 *an independent contractor, reported on an IRS Form 1099, or*  
12 *both.*

13 (1) If employed, a clinical counselor intern shall provide the  
14 board with copies of the corresponding W-2 tax forms for each  
15 year of experience claimed upon application for licensure as a  
16 professional clinical counselor.

17 (2) If volunteering, a clinical counselor intern shall provide the  
18 board with a letter from his or her employer verifying the intern's  
19 employment as a volunteer upon application for licensure as a  
20 professional clinical counselor.

21 (b) Clinical counselor trainees, interns, and applicants shall not  
22 receive any remuneration from patients or clients, and shall only  
23 be paid by their employers.

24 (c) While an intern may be either a paid employee or a volunteer,  
25 employers are encouraged to provide fair remuneration.

26 (d) Clinical counselor trainees, interns, and applicants who  
27 provide voluntary services or other services, and who receive no  
28 more than a total, from all work settings, of five hundred dollars  
29 (\$500) per month as reimbursement for expenses actually incurred  
30 by those clinical counselor trainees, interns, and applicants for  
31 services rendered in any lawful work setting other than a private  
32 practice shall be considered an employee and not an independent  
33 contractor.

34 (e) The board may audit an intern or applicant who receives  
35 reimbursement for expenses and the intern or applicant shall have  
36 the burden of demonstrating that the payments received were for  
37 reimbursement of expenses actually incurred.

38 (f) Clinical counselor trainees, interns, and applicants shall only  
39 perform services at the place where their employer regularly  
40 conducts business and services, which may include other locations,

1 as long as the services are performed under the direction and  
2 control of the employer and supervisor in compliance with the  
3 laws and regulations pertaining to supervision. Clinical counselor  
4 trainees, interns, and applicants shall have no proprietary interest  
5 in the employer's business.

6 (g) Each educational institution preparing applicants for  
7 licensure pursuant to this chapter shall consider requiring, and  
8 shall encourage, its students to undergo individual, marital or  
9 conjoint, family, or group counseling or psychotherapy, as  
10 appropriate. Each supervisor shall consider, advise, and encourage  
11 his or her interns and clinical counselor trainees regarding the  
12 advisability of undertaking individual, marital or conjoint, family,  
13 or group counseling or psychotherapy, as appropriate. Insofar as  
14 it is deemed appropriate and is desired by the applicant, the  
15 educational institution and supervisors are encouraged to assist  
16 the applicant in locating that counseling or psychotherapy at a  
17 reasonable cost.

18 SEC. 21. Section 4999.52 of the Business and Professions  
19 Code is amended to read:

20 ~~4999.52. (a) Except as provided in Section 4999.54, every~~  
21 *Every* applicant for a license as a professional clinical counselor  
22 shall be examined by the board. The board shall examine the  
23 candidate with regard to his or her knowledge and professional  
24 skills and his or her judgment in the utilization of appropriate  
25 techniques and methods.

26 (b) The examinations shall be given at least twice a year at a  
27 time and place and under supervision as the board may determine.

28 (c) The board shall not deny any applicant who has submitted  
29 a complete application for examination admission to the licensure  
30 examinations required by this section if the applicant meets the  
31 educational and experience requirements of this chapter, and has  
32 not committed any acts or engaged in any conduct that would  
33 constitute grounds to deny licensure.

34 (d) The board shall not deny any applicant whose application  
35 for licensure is complete admission to the examinations specified  
36 by paragraph (2) of subdivision (a) of Section 4999.53, nor shall  
37 the board postpone or delay this examination for any applicant or  
38 delay informing the candidate of the results of this examination,  
39 solely upon the receipt by the board of a complaint alleging acts  
40 or conduct that would constitute grounds to deny licensure.

1 (e) If an applicant for the examination specified by paragraph  
2 (2) of subdivision (a) of Section 4999.53, who has passed the  
3 California law and ethics examination, is the subject of a complaint  
4 or is under board investigation for acts or conduct that, if proven  
5 to be true, would constitute grounds for the board to deny licensure,  
6 the board shall permit the applicant to take this examination, but  
7 may notify the applicant that licensure will not be granted pending  
8 completion of the investigation.

9 (f) Notwithstanding Section 135, the board may deny any  
10 applicant who has previously failed either the California law and  
11 ethics examination, or the examination specified by paragraph (2)  
12 of subdivision (a) of Section 4999.53, permission to retake either  
13 examination pending completion of the investigation of any  
14 complaints against the applicant.

15 (g) Nothing in this section shall prohibit the board from denying  
16 an applicant admission to any examination, withholding the results,  
17 or refusing to issue a license to any applicant when an accusation  
18 or statement of issues has been filed against the applicant pursuant  
19 to Section 11503 or 11504 of the Government Code, respectively,  
20 or the application has been denied in accordance with subdivision  
21 (b) of Section 485.

22 (h) Notwithstanding any other provision of law, the board may  
23 destroy all examination materials two years following the date of  
24 an examination.

25 (i) On and after January 1, 2016, the examination specified by  
26 paragraph (2) of subdivision (a) of Section 4999.53 shall be passed  
27 within seven years of an applicant's initial attempt.

28 (j) A passing score on the clinical examination shall be accepted  
29 by the board for a period of seven years from the date the  
30 examination was taken.

31 (k) No applicant shall be eligible to participate in the  
32 examination specified by paragraph (2) of subdivision (a) of  
33 Section 4999.53, if he or she fails to obtain a passing score on this  
34 examination within seven years from his or her initial attempt. If  
35 the applicant fails to obtain a passing score within seven years of  
36 initial attempt, he or she shall obtain a passing score on the current  
37 version of the California law and ethics examination in order to  
38 be eligible to retake this examination.

39 (l) This section shall become operative on January 1, 2016.



1 SEC. 22. Section 4999.54 of the Business and Professions  
2 Code is repealed.

3 ~~4999.54. (a) Notwithstanding Section 4999.50, the board may~~  
4 ~~issue a license to any person who submits an application for a~~  
5 ~~license between January 1, 2011, and December 31, 2011, provided~~  
6 ~~that all documentation is submitted within 12 months of the board's~~  
7 ~~evaluation of the application, and provided he or she meets one of~~  
8 ~~the following sets of criteria:~~

9 (1) ~~He or she meets all of the following requirements:~~

10 (A) ~~Has a master's or doctoral degree from a school, college,~~  
11 ~~or university as specified in Section 4999.32, that is counseling or~~  
12 ~~psychotherapy in content. If the person's degree does not include~~  
13 ~~all the graduate coursework in all nine core content areas as~~  
14 ~~required by paragraph (1) of subdivision (c) of Section 4999.32,~~  
15 ~~a person shall provide documentation that he or she has completed~~  
16 ~~the required coursework prior to licensure pursuant to this chapter.~~  
17 ~~Except as specified in clause (ii), a qualifying degree must include~~  
18 ~~the supervised practicum or field study experience as required in~~  
19 ~~paragraph (3) of subdivision (c) of Section 4999.32.~~

20 (i) ~~A counselor educator whose degree contains at least seven~~  
21 ~~of the nine required core content areas shall be given credit for~~  
22 ~~coursework not contained in the degree if the counselor educator~~  
23 ~~provides documentation that he or she has taught the equivalent~~  
24 ~~of the required core content areas in a graduate program in~~  
25 ~~counseling or a related area.~~

26 (ii) ~~Degrees issued prior to 1996 shall include a minimum of~~  
27 ~~30 semester units or 45 quarter units and at least six of the nine~~  
28 ~~required core content areas specified in paragraph (1) of subdivision~~  
29 ~~(c) of Section 4999.32 and three semester units or four and one-half~~  
30 ~~quarter units of supervised practicum or field study experience.~~  
31 ~~The total number of units shall be no less than 48 semester units~~  
32 ~~or 72 quarter units.~~

33 (iii) ~~Degrees issued in 1996 and after shall include a minimum~~  
34 ~~of 48 semester units or 72 quarter units and at least seven of the~~  
35 ~~nine core content areas specified in paragraph (1) of subdivision~~  
36 ~~(c) of Section 4999.32.~~

37 (B) ~~Has completed all of the coursework or training specified~~  
38 ~~in subdivision (c) of Section 4999.32.~~

39 (C) ~~Has at least two years, full-time or the equivalent, of~~  
40 ~~postdegree counseling experience, that includes at least 1,700 hours~~

1 of experience in a clinical setting supervised by a licensed marriage  
2 and family therapist, a licensed clinical social worker, a licensed  
3 psychologist, a licensed physician and surgeon specializing in  
4 psychiatry, a professional clinical counselor or a person who is  
5 licensed in another state to independently practice professional  
6 clinical counseling, as defined in Section 4999.20, or a master's  
7 level counselor or therapist who is certified by a national certifying  
8 or registering organization, including, but not limited to, the  
9 National Board for Certified Counselors or the Commission on  
10 Rehabilitation Counselor Certification.

11 (D) Has a passing score on the following examinations:

12 (i) ~~The National Counselor Examination for Licensure and~~  
13 ~~Certification or the Certified Rehabilitation Counselor~~  
14 ~~Examination.~~

15 (ii) ~~The National Clinical Mental Health Counselor Examination.~~

16 (iii) ~~A California jurisprudence and ethics examination, when~~  
17 ~~developed by the board.~~

18 (2) ~~Is currently licensed as a marriage and family therapist in~~  
19 ~~the State of California, meets the coursework requirements~~  
20 ~~described in subparagraph (A) of paragraph (1), and passes the~~  
21 ~~examination described in subdivision (b).~~

22 (3) ~~Is currently licensed as a clinical social worker in the State~~  
23 ~~of California, meets the coursework requirements described in~~  
24 ~~subparagraph (A) of paragraph (1), and passes the examination~~  
25 ~~described in subdivision (b).~~

26 (b) (1) ~~The board and the Office of Professional Examination~~  
27 ~~Services shall jointly develop an examination on the differences,~~  
28 ~~if any differences exist, between the following:~~

29 (A) ~~The practice of professional clinical counseling and the~~  
30 ~~practice of marriage and family therapy.~~

31 (B) ~~The practice of professional clinical counseling and the~~  
32 ~~practice of clinical social work.~~

33 (2) ~~If the board, in consultation with the Office of Professional~~  
34 ~~Examination Services, determines that an examination is necessary~~  
35 ~~pursuant to this subdivision, an applicant described in paragraphs~~  
36 ~~(2) and (3) of subdivision (a) shall pass the examination as a~~  
37 ~~condition of licensure.~~

38 (e) ~~Nothing in this section shall be construed to expand or~~  
39 ~~constrict the scope of practice of professional clinical counseling,~~  
40 ~~as defined in Section 4999.20.~~

1 SEC. 23. Section 4999.60 of the Business and Professions  
2 Code is amended to read:

3 4999.60. (a) This section applies to persons who are licensed  
4 outside of California and apply for examination eligibility on or  
5 after January 1, 2016.

6 (b) The board may issue a license to a person who, at the time  
7 of submitting an application for a license pursuant to this chapter,  
8 holds a valid license as a professional clinical counselor, or other  
9 counseling license that allows the applicant to independently  
10 provide clinical mental health services, in another jurisdiction of  
11 the United States, if all of the following conditions are satisfied:

12 (1) The applicant's education is substantially equivalent, as  
13 defined in Section 4999.63.

14 (2) The applicant complies with subdivision-~~(b)~~ (c) of Section  
15 4999.40, if applicable.

16 (3) The applicant's supervised experience is substantially  
17 equivalent to that required for a license under this chapter. The  
18 board shall consider hours of experience obtained outside of  
19 California during the six-year period immediately preceding the  
20 date the applicant initially obtained the license described above.  
21 If the applicant has less than 3,000 hours of qualifying supervised  
22 experience, time actively licensed as a professional clinical  
23 counselor shall be accepted at a rate of 100 hours per month up to  
24 a maximum of 1,200 hours if the applicant's degree meets the  
25 practicum requirement described in subparagraph (C) of paragraph  
26 (1) of subdivision (b) of Section 4999.63 without exemptions or  
27 remediation.

28 (4) The applicant passes the examinations required to obtain a  
29 license under this chapter. An applicant who obtained his or her  
30 license or registration under another jurisdiction may apply for  
31 licensure with the board without taking the clinical examination  
32 if both of the following conditions are met:

33 (A) The applicant obtained a passing score on the licensing  
34 examination set forth in regulation as accepted by the board.

35 (B) The applicant's license or registration in that jurisdiction is  
36 in good standing at the time of his or her application and is not  
37 revoked, suspended, surrendered, denied, or otherwise restricted  
38 or encumbered.

39 SEC. 24. Section 4999.61 of the Business and Professions  
40 Code is amended to read:

1 4999.61. (a) This section applies to persons who apply for  
2 examination eligibility or registration on or after January 1, 2016,  
3 and who do not hold a license as described in Section 4999.60.

4 (b) The board shall accept education gained while residing  
5 outside of California for purposes of satisfying licensure or  
6 registration requirements if the education is substantially  
7 equivalent, as defined in Section 4999.62, and the applicant  
8 complies with subdivision ~~(b)~~ (c) of Section 4999.40, if applicable.

9 (c) The board shall accept experience gained outside of  
10 California for purposes of satisfying licensure or registration  
11 requirements if the experience is substantially equivalent to that  
12 required by this chapter.

13 SEC. 25. Section 4999.120 of the Business and Professions  
14 Code is amended to read:

15 4999.120. The board shall assess fees for the application for  
16 and the issuance and renewal of licenses and for the registration  
17 of interns to cover administrative and operating expenses of the  
18 board related to this chapter. Fees assessed pursuant to this section  
19 shall not exceed the following:

20 (a) The fee for the application for examination eligibility shall  
21 be up to two hundred fifty dollars (\$250).

22 (b) The fee for the application for intern registration shall be up  
23 to one hundred fifty dollars (\$150).

24 (c) The fee for the application for licensure shall be up to one  
25 hundred eighty dollars (\$180).

26 (d) The fee for the board-administered clinical examination, if  
27 the board chooses to adopt this examination in regulations, shall  
28 be up to two hundred fifty dollars (\$250).

29 (e) The fee for the law and ethics examination shall be up to  
30 one hundred fifty dollars (\$150).

31 ~~(f) The fee for the examination described in subdivision (b) of~~  
32 ~~Section 4999.54 shall be up to one hundred dollars (\$100).~~

33 ~~(g)~~

34 (f) The fee for the issuance of a license shall be up to two  
35 hundred fifty dollars (\$250).

36 ~~(h)~~

37 (g) The fee for annual renewal of an intern registration shall be  
38 up to one hundred fifty dollars (\$150).

39 (i)

1     (*h*) The fee for two-year renewal of licenses shall be up to two  
2 hundred fifty dollars (\$250).

3     ~~(*j*)~~

4     (*i*) The fee for issuance of a retired license shall be forty dollars  
5 (\$40).

6     ~~(*k*)~~

7     (*j*) The fee for rescoring an examination shall be twenty dollars  
8 (\$20).

9     ~~(*t*)~~

10    (*k*) The fee for issuance of a replacement license or registration  
11 shall be twenty dollars (\$20).

12    ~~(*m*)~~

13    (*l*) The fee for issuance of a certificate or letter of good standing  
14 shall be twenty-five dollars (\$25).

15    SEC. 26. No reimbursement is required by this act pursuant to  
16 Section 6 of Article XIII B of the California Constitution because  
17 the only costs that may be incurred by a local agency or school  
18 district will be incurred because this act creates a new crime or  
19 infraction, eliminates a crime or infraction, or changes the penalty  
20 for a crime or infraction, within the meaning of Section 17556 of  
21 the Government Code, or changes the definition of a crime within  
22 the meaning of Section 6 of Article XIII B of the California  
23 Constitution.



## MEMORANDUM

<b>DATE</b>	July 12, 2016
<b>TO</b>	Legislative & Regulatory Committee Members
<b>FROM</b>	Lusine M Sarkisyan, Legislative and Regulatory Analyst
<b>SUBJECT</b>	<b>Agenda Item 19C:</b> Update on 2016 Pending Regulatory Packages

### **Abandonment of Applications (California Code of Regulations, Title 16, Section 1004):**

During the May 2013 meeting, the Dental Board of California (Board) approved proposed regulatory language relative to the abandonment of applications and directed staff to initiate the rulemaking. Board staff filed the initial rulemaking documents with the Office of Administrative Law (OAL) on July 23, 2015 and the proposal was published in the California Regulatory Notice Register on Friday, August 7, 2015. The 45-day public comment period began on August 7, 2015 and ended on September 21, 2015. A public regulatory hearing was held in Sacramento on September 22, 2015. The Board did not receive comments. Since, there were no comments the Board adopted the proposed language and directed staff to finalize the rulemaking file.

Staff submitted the final rulemaking file to the Department of Consumer Affairs (Department) on September 28, 2015. Final rulemaking files were approved by the Director of the Department on May 12, 2016, and the Secretary of the Business, Consumer Services, and Housing Agency (Agency) on June 24, 2016. Currently, it is pending signature approval by the Director of the Department of Finance (Finance).

Final rulemaking files are required to be approved by the Director of the Department, the Agency Secretary, and the Finance Director. Once approval signatures are obtained, the final rulemaking file will be submitted to the OAL. The OAL will have thirty (30) working days to review the file. Once approved, the rulemaking will be filed with the Secretary of State. Beginning January 1, 2013, new quarterly effective dates for regulations will be dependent upon the timeframe an OAL approved rulemaking is filed with the Secretary of State, as follows:

- The regulation would take effect on January 1 if the OAL approved rulemaking is filed with the Secretary of State on September 1 to November 30, inclusive.

- The regulation would take effect on April 1 if the OAL approved rulemaking is filed with the Secretary of State on December 1 to February 29, inclusive.
- The regulation would take effect on July 1 if the OAL approved rulemaking is filed with the Secretary of State on March 1 to May 31, inclusive.
- The regulation would take effect on October 1 if the OAL approved regulation is filed on June 1 to August 31, inclusive.

The deadline to submit this final rulemaking file to the Office of Administrative Law for review and determination of approval is August 6, 2016.

**Dental Assisting Comprehensive Regulatory Proposal:**

The Dental Assisting Council (Council) held multiple regulatory development workshops as part of the Dental Assisting Comprehensive Regulatory Proposal: March 18, 2016 worked on the Radiation Safety Course Requirements and Minimum Standards for Infection Control; April 29, 2016 worked on Minimum Standards for Infection Control and regulatory language relating to the Approval of Pit & Fissure Sealant, Coronal Polishing, and Ultrasonic Scaling Courses; June 10, 2016 worked on Orthodontic Assistant Permits; and July 15, 2016 worked on the Registered Dental Assistant program. The workshops resulted in fruitful discussions and feedback from the Council and stakeholders. Board staff scheduled the next workshop for September 16, 2016 to develop proposed regulatory language to present to the Board at a future meeting. Once the workshops are completed, the rulemaking will consist of proposed amendments that will impact educational program and course requirements, examination requirements, and licensure requirements relating to dental assisting. This rulemaking will be presented to the Board at a future meeting.

**Elective Facial Cosmetic Surgery Permit Application Requirements and Renewal:**

Regulations were deemed necessary to interpret and specify the provisions contained in Business and Professions Code Section 1638.1 relating to the application and approval process requirements for the issuance of an Elective Facial Cosmetic Surgery permit. Board staff scheduled a teleconference in October where further discussions took place regarding regulatory language. On April 20, 2016, the Elective Facial Cosmetic Surgery (EFCS) Permit Credentialing Committee considered the proposed language, however directed staff to add additional language relating to operative reports. The EFCS Committee was scheduled to meet on July 13, 2016, however because no permit applications were received the meeting was canceled. The next Committee meeting is scheduled on October 19, 2016 at which time the Committee will consider the proposed language and recommend to the Board to proceed with the rulemaking.

**Licensure by Credential Application Requirements:**

The Board added this rulemaking to its list of priorities for Fiscal Year (FY) 2015-16. Staff worked with Board Legal Counsel to identify issues and develop regulatory language to implement, interpret, and specify the application requirements for the Licensure by Credential pathway to licensure. The Board appointed a subcommittee (Drs. Witcher and Woo) to work with staff to draft regulatory language and to determine if statutory changes are necessary. Staff met with the subcommittee and the Board's Legal Counsel in October 2015 and as a result of that meeting, staff presented a few policy issues to the Board for recommendation during the December 2015 Board meeting. Staff is working to incorporate the recommendations in the development of the regulatory language to proceed forward in the rulemaking process which will be presented to the Board at a future meeting.

## **Continuing Education Requirements and Basic Life Support Equivalency**

### **Standards:**

In March 2013, the Board's Executive Officer received a letter from Mr. Ralph Shenefelt, Senior Vice President of the Health and Safety Institute, petitioning the Board to amend California Code of Regulations, Title 16, Sections 1016(b)(1)(C) and 1017(d) such that a Basic Life Support (BLS) certification issued by the American Safety and Health Institute (ASHI), which is a brand of the Health and Safety Institute, would satisfy the mandatory BLS certification requirement for license renewal, and the required advanced cardiac life support course required for the renewal of a general anesthesia permit. Additionally, the letter requested an amendment to Section 1017(d) to specify that an advanced cardiac life support course which is approved by the American Heart Association or the ASHI include an examination on the materials presented in the course or any other advanced cardiac life support course which is identical in all respects, except for the omission of materials that relate solely to hospital emergencies or neonatology, to the most recent "American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care" published by the American Heart Association.

Additionally, AB 836 (Skinner Chapter 299, statutes of 2013) restricted the continuing education requirement hours for active-retired dentists who provide only uncompensated care at a maximum of 60% of that required for non-retired active dentists, and requires the Board to report on the status of retired active dentists who provide only uncompensated care during its next sunset report. These new requirements were implemented as part of its rulemaking proposal.

Board staff is working on the development of proposed language and will present it to the Board for consideration at a future meeting.

### **Mobile and Portable Dental Unit Registration Requirements (California Code of Regulations, Title 16, Section 1049):**

Senate Bill 562 (Galgiani Chapter 562, Statute of 2013) eliminated the one mobile dental clinic or unit limit and required a mobile dental unit or a dental practice that routinely uses portable dental units, as defined, to be registered and operated in accordance with the regulations of the Board. The bill required any regulations adopted by the board pertaining to this matter to require the registrant to identify a licensed dentist responsible for the mobile dental unit or portable practice, and to include requirements for availability to follow-up and emergency care, maintenance and availability of provider and patient records, and treatment information to be provided to patients and other appropriate parties. At its November 2014 meeting, the Board directed staff to add Mobile and Portable Dental Units to its list of regulatory priorities in order to interpret and specify the provisions relating to the registration requirements for the issuance of a mobile and portable dental unit. In December 2015, staff met and worked with the California Dental Association (CDA) to further develop regulatory language which was presented to the Board for consideration during the March 2016 meeting.

During the March 2016 Board meeting, the Board approved proposed regulatory language for the Mobile Dental Clinic and Portable Dental Unit Registration Requirements. Board staff is currently drafting the initial rulemaking documents for submittal to OAL.



**Dentistry and Dental Assisting Licensing and Permitting Fee Increase (California Code of Regulation, Title 16, Sections 1021 and 1022):**

On May 12, 2016, the Board approved the proposed regulatory language relative to dentistry and dental assisting licensing and permitting fees and directed staff to initiate the rulemaking. Board staff filed the initial rulemaking documents with the Office of Administrative Law (OAL) on June 14, 2016 and the proposal was published in the California Regulatory Notice Register on Friday, June 24, 2016. The 45-day public comment period began on June 24, 2016 and ended on August 8, 2016. A public regulatory hearing was held in Sacramento on August 9, 2016.

**Defining Discovery and Filing (California Code of Regulation, Title 16, Sections 1001.1 and 1001.2):**

During the March 2016 Board meeting, Assistant Executive Officer, Sarah Wallace, discussed the advisement of the Attorney General's Office regarding the promulgation of regulations, as done by the Medical Board of California, to define the terms "discovery" and "filing" as found in the Business and Professions Code Section 1670.2. Staff worked with the Board's Legal Counsel to draft language in defining "discovery" and "filing", which was presented during the May 2016 Board meeting. The Board initiated the rulemaking file for this regulatory package. Board staff drafted the initial rulemaking documents which will be submitted to OAL.

**Action Requested:**

No Action Requested.



## MEMORANDUM

<b>DATE</b>	July 8, 2016
<b>TO</b>	Members of the Dental Board of California
<b>FROM</b>	Lusine M Sarkisyan, Legislative & Regulatory Analyst
<b>SUBJECT</b>	<b>Agenda Item 19D:</b> Discussion and Possible Action Regarding Fiscal Year 2016-17 Regulatory Priorities

### **Background:**

At the beginning of each Fiscal Year (FY), staff requests the Dental Board of California (Board) set its priorities for the promulgation of new regulatory proposals for the duration of the year so that staff may manage the workload associated with meeting the Board's goals accordingly. In 2015, the Board set the following priorities, in priority order, for FY 2015-16:

1. Delegation of Authority to the Board's Executive Officer;
2. Abandonment of Applications;
3. Dental Assisting Comprehensive Rulemaking
4. Licensure by Credential Application Requirements;
5. Continuing Education Requirements and Basic Life Support Equivalency Standards;
6. Mobile and Portable Dental Unit Registration Requirements;
7. Elective Facial Cosmetic Surgery (EFCS) Permit Requirements;
8. Dentistry and Dental Assisting Fee increase; and
9. Statute of Limitations and Filing.

The following is a list of regulatory proposals that were approved by Office of Administrative Law (OAL):

### **1. Delegation of Authority to the Executive Officer (California Code of Regulations, Title 16, Section 1001):**

At its May 2014 meeting, the Board approved proposed regulatory language to delegate authority to the Board's Executive Officer to approve settlement agreements for the revocation, surrender, or interim suspension of a license without requiring the Board to vote to adopt the settlement. Board staff filed the initial rulemaking documents with OAL on February 10, 2015 and the proposal was published in the California Regulatory Notice on February 20, 2015. The 45-day

public comment period began on February 20, 2015 and ended on April 6, 2015. A regulatory hearing was held on April 7, 2015 in Sacramento. No public comments were received in response to the proposal.

Staff submitted the final rulemaking file to the Department of Consumer Affairs (Department) on June 17, 2015. Final rulemaking files were approved by the Director of the Department, the Secretary of the Business, Consumer Services, and Housing Agency (Agency) and the Director of the Department of Finance (Finance). On January 22, 2016, the final rulemaking file was submitted to the OAL. The OAL reviewed the file and approved the rulemaking on March 7, 2016, which was filed with the Secretary of State. The rulemaking has become effective as of July 1, 2016. **Status: Rulemaking has been approved.**

The following is a list of regulatory proposals that staff has been working on over the last year:

**1. Abandonment of Applications (California Code of Regulations, Title 16, Section 1004):**

At its May 2013 meeting, the Dental Board of California (Board) approved proposed regulatory language relative to the abandonment of applications and directed staff to initiate the rulemaking. Board staff filed the initial rulemaking documents with the Office of Administrative Law (OAL) on July 23, 2015 and the proposal was published in the California Regulatory Notice Register on Friday, August 7, 2015. The 45-day public comment period began on August 7, 2015 and ended on September 21, 2015. A public regulatory hearing was held in Sacramento on September 22, 2015. No public comments were received in response to the proposal.

Staff submitted the final rulemaking file to the Department of Consumer Affairs (Department) on September 28, 2015. Final rulemaking files were approved by the Director of the Department on May 12, 2016, and the Secretary of the Business, Consumer Services, and Housing Agency (Agency) on June 24, 2015. Currently, it is pending signature approval by the Director of the Department of Finance (Finance). Once all the necessary approval signatures are obtained, the final rulemaking file will be submitted to the Office of Administrative Law. The Office of Administrative Law will have thirty (30) working days to review the file. Once approved, the rulemaking will be filed with the Secretary of State. Beginning January 1, 2013, new quarterly effective dates for regulations will be dependent upon the timeframe an OAL approved rulemaking is filed with the Secretary of State. The deadline to submit this final rulemaking file to the Office of Administrative Law review and determination of approval is August 6, 2016. **Status: Pending signature approval by Finance.**

**2. Dental Assisting Comprehensive Regulatory Proposal:**

The Dental Assisting Council (Council) has held multiple regulatory development workshops throughout the year to work on various components of the Dental Assisting Comprehensive Regulatory Proposal. Board staff anticipates presenting the proposed regulatory language to the Board at a future meeting. Once completed, this rulemaking will include educational program and course requirements, examination requirements, and licensure requirements relating to dental assisting.

**Status: Pending further development of regulatory language by the Dental Assisting Council.**

**3. Licensure by Credential Application Requirements:**

The Board added this rulemaking to its list of priorities for Fiscal Year (FY) 2015-16. Staff worked with Board Legal Counsel to identify issues and develop regulatory language to implement, interpret, and specify the application requirements for the Licensure by Credential pathway to licensure. The Board appointed a subcommittee (Drs. Whitcher and Woo) to work with staff to draft regulatory language and to determine if statutory changes are necessary. Staff met with the subcommittee and the Board's Legal Counsel in October 2015 and as a result of that meeting, staff presented a few policy issues to the Board for recommendation during the December 2015 Board meeting. Staff is working to incorporate the recommendations in the development of the regulatory language to proceed forward in the rulemaking process. **Status: Pending additional language development by Board subcommittee, staff, and Legal Counsel.**

**4. Continuing Education Requirements and Basic Life Support Equivalency Standards:**

In March 2013, the Board's Executive Officer received a letter from Mr. Ralph Shenefelt, Senior Vice President of the Health and Safety Institute, petitioning the Board to amend California Code of Regulations, Title 16, Sections 1016(b)(1)(C) and 1017(d) such that a Basic Life Support (BLS) certification issued by the American Safety and Health Institute (ASHI), which is a brand of the Health and Safety Institute, would satisfy the mandatory BLS certification requirement for license renewal, and the required advanced cardiac life support course required for the renewal of a general anesthesia permit. Additionally, the letter requested an amendment to Section 1017(d) to specify that an advanced cardiac life support course which is approved by the American Heart Association or the ASHI include an examination on the materials presented in the course or any other advanced cardiac life support course which is identical in all respects, except for the omission of materials that relate solely to hospital emergencies or neonatology, to the most recent "American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care" published by the American Heart Association.

Additionally, AB 836 (Skinner Chapter 299, statutes of 2013) restricted the continuing education requirement hours for active-retired dentists who provide only uncompensated care at a maximum of 60% of that required for non-retired active dentists, and requires the Board to report on the status of retired active dentists who provide only uncompensated care during its next sunset report. These new requirements were implemented as part of its rulemaking proposal.

Board staff is working on the development of proposed language and will present it to the Board for consideration at a future meeting. **Status: Pending development of proposed language for Board consideration.**

**5. Mobile and Portable Dental Unit Registration Requirements:**

Senate Bill 562 (Galgiani Chapter 562, Statute of 2013) eliminated the one mobile dental clinic or unit limit and required a mobile dental unit or a dental practice that routinely uses portable dental units, a defined, to be registered and operated in

accordance with the regulations of the Board. The bill required any regulations adopted by the board pertaining to this matter to require the registrant to identify a licensed dentist responsible for the mobile dental unit or portable practice, and to include requirements for availability to follow-up and emergency care, maintenance and availability of provider and patient records, and treatment information to be provided to patients and other appropriate parties. At its November 2014 meeting, the Board directed staff to add Mobile and Portable Dental Units to its list of regulatory priorities in order to interpret and specify the provisions relating to the registration requirements for the issuance of a mobile and portable dental unit. In December 2015, staff met and worked with the California Dental Association (CDA) to further develop regulatory language which was presented to the Board for consideration during the March 2016 meeting.

During the March 2016 Board meeting, the Board approved proposed regulatory language for the Mobile Dental Clinic and Portable Dental Unit Registration Requirements. Board staff is currently drafting the initial rulemaking documents for submittal to OAL. **Status: Pending submission of rulemaking documents to OAL.**

#### **6. Elective Facial Cosmetic Surgery Permit Application Requirements and Renewal:**

Regulations were deemed necessary to interpret and specify the provisions contained in Business and Professions Code Section 1638.1 relating to the application and approval process requirements for the issuance of an Elective Facial Cosmetic Surgery permit. Board staff scheduled a teleconference in October where further discussions took place regarding regulatory language. On April 20, 2016, the Elective Facial Cosmetic Surgery (EFCS) Permit Credentialing Committee considered the proposed language, however directed staff to add additional language relating to operative reports. The EFCS Committee was scheduled to meet on July 13, 2016, however because no permit applications were received the meeting was canceled. The next Committee meeting is scheduled on October 19, 2016 at which time the Committee will consider the proposed language and recommend to the Board to proceed with the rulemaking. **Status: Pending approval of regulatory language by the EFCS Permit Credentialing Committee.**

#### **7. Dentistry and Dental Assisting Licensing and Permitting Fee Increase (California Code of Regulation, Title 16, Sections 1021 and 1022):**

On May 12, 2016, the Board approved the proposed regulatory language relative to dentistry and dental assisting licensing and permitting fees and directed staff to initiate the rulemaking. Board staff filed the initial rulemaking documents with the Office of Administrative Law (OAL) on June 14, 2016 and the proposal was published in the California Regulatory Notice Register on Friday, June 24, 2016. The 45-day public comment period began on June 24, 2016 and ended on August 8, 2016. A public regulatory hearing was held in Sacramento on August 9, 2016. **Status: Pending 45-day public comment period.**

#### **8. Defining Discovery and Filing (California Code of Regulation, Title 16, Sections 1001.1 and 1001.2):**

At the March 2016 Board meeting the advisement of the Attorney General's Office was discussed regarding the promulgation of regulations, as done by the Medical

Board of California, to define the terms “discovery” and “filing” as found in the Business and Professions Code Section 1670.2. On May 12, 2016, Board approved the proposed regulatory language and directed staff to initiate the rulemaking.

**Status: Pending submission of rulemaking documents to OAL.**

Board staff maintains a list of needed regulations for the Board to consider when prioritizing regulatory proposals each fiscal year. This list includes regulatory proposals that would not need legislative amendments prior to promulgation. The following is a list of needed regulatory proposals for the Board’s consideration:

1. Memo Requesting Change Without Regulatory Effect to California Code of Regulations, Title 16, Sections 1023.16 and 1023.7
2. Institutional Standards (Cal. Code of Regs., Title 16, Section 1024.1)
3. Interim Therapeutic Restoration (ITR) Competency Standards for Instruction (New Regulations)

**Staff Recommendation**

Staff recommends the Board consider maintaining the same regulatory priorities it established in FY 2015-16 as the regulatory priorities for FY 2016-17 to allow the opportunity to complete what is currently pending.

**Action Requested:**

Staff requests the Board review the list of issues that require rulemakings and establish a priority list to assist staff with determining workload for FY 2016-2017.



## MEMORANDUM

<b>DATE</b>	June 8, 2016
<b>TO</b>	Legislative and Regulatory Committee
<b>FROM</b>	Lusine Sarkisyan, Legislative and Regulatory Analyst Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 19E:</b> Discussion of Prospective Legislative Proposals

Stakeholders are encouraged to submit proposals in writing to the Board before or during the meeting for possible consideration by the Board at a future Board meeting.



## MEMORANDUM

<b>DATE</b>	August 2, 2016
<b>TO</b>	Dental Board Members
<b>FROM</b>	Lusine M Sarkisyan, Legislative and Regulatory Analyst
<b>SUBJECT</b>	<b>Agenda Item 20(A):</b> Discussion and Possible Action Regarding Comments Received During the 45-Day Public Comment Period for the Board's Proposed Rulemaking to Amend §1021 and 1022 of Title 16 of the California Code of Regulations Relating to Dentistry and Dental Assisting Licensing and Permitting Fee Increase

### **Background:**

At its May 2016 meeting, the Dental Board of California (Board) approved proposed regulatory language relative to dentistry and dental assisting licensing and permitting fee increase and directed staff to initiate the rulemaking. Board staff filed the initial rulemaking documents with the Office of Administrative Law (OAL) on June 14<sup>th</sup> and the proposal was published in the California Regulatory Notice Register on Friday, June 24, 2016. The 45-day public comment period began on Friday, June 24, 2016. The comment period will end on Monday, August 8, 2016.

After the scheduled regulatory hearing in Sacramento on Monday, August 8, 2016, a supplemental document will be presented to the Board which will include any written comments received during the regulatory hearing for the Board to take action and recommended responses.





## MEMORANDUM

<b>DATE</b>	August 2, 2016
<b>TO</b>	Dental Board Members
<b>FROM</b>	Lusine M Sarkisyan, Legislative and Regulatory Analyst
<b>SUBJECT</b>	<b>Agenda Item 20(B):</b> Discussion and Possible Action Regarding Adoption of Proposed Amendments to California Code of Regulations, Title 16, Sections 1021 and 1022 Relevant to a Dentistry and Dental Assisting Fee Increase

### **Background:**

The Board may consider comments received during the 45-day public comment period, hold discussion, and take action to adopt proposed amendments to California Code of Regulations, Title 16, Sections 1021 and 1022 relevant to the dentistry and dental assisting fee increase.

### **Action Requested:**

The Board may hold discussion regarding adverse comments received during the 45-day public comment period and may take one of the following actions:

- A. If the Board rejects the comments received during the 45-day public comment period, and does not vote to modify the text in response to comments, then the Board would:

Direct staff to take all steps necessary to complete the rulemaking process, including the filing of the final rulemaking package with the Office of Administrative Law and authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopt the proposed amendments to California Code of Regulations, Title 16, Sections 1021 and 1022 relevant the dentistry fee increase as noticed in the proposed text.

- B. If the Board accepts any comments received during the 45-day public comment period, or modifies the text in response to comments, then the Board would:

Modify the text in response to the comments received and direct staff to take all steps necessary to complete the rulemaking process, including preparing the modified text for a 15-day public comment period, which includes the amendments accepted by the board at this meeting. If after the 15-day public comment period,

no adverse comments are received, authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopt the proposed amendments to California Code of Regulations, Title 16, Section 1021 and 1022 relevant to the dentistry and dental assisting fee increase as noticed in the modified text.

# **Public Comment on Items Not on the Agenda.**

**The Board may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).**

# **Board Member Comments on Items Not on the Agenda.**

**The Board may not discuss or take action on any matter raised during the Board Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).**

**ADJOURNMENT**